HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
APRIL 23, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	East Tennessee Children's Hospital
PROJECT NUMBER:	CN1401-002
ADDRESS:	2018 Clinch Avenue Knoxville (Knox County), Tennessee 37916
LEGAL OWNER:	East Tennessee Children's Hospital Association, Inc. 2018 Clinch Avenue Knoxville (Knox County), Tennessee 37916
OPERATING ENTITY:	Not Applicable
CONTACT PERSON:	Kim H. Looney (615) 850-8722
DATE FILED:	January 15, 2014
PROJECT COST:	$75,302,000
FINANCING:	Cash Reserves and Tax-Exempt Bonds
PURPOSE OF REVIEW:	Hospital Construction and Renovation in Excess of $5 Million

DESCRIPTION:

East Tennessee Children's Hospital (ETCH) is seeking approval for the renovation and expansion of the hospital's existing Neonatal Abstinence Syndrome Unit, Neonatal Intensive Care Unit (NICU), Preoperative Services, and Specialty Clinic located on the Hospital's campus at 2018 Clinch Avenue, Knoxville (Knox County), TN 37916. The licensed beds will not be affected, no services will be initiated, and no major medical equipment will be purchased.

CRITERIA AND STANDARDS REVIEW

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

2. **For renovation or expansions of an existing licensed health care institution:**

   a. **The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**

      The ETCH Neonatal Intensive Care Bed (Levels II-B and III-B) utilization increased from 13,079 days in 2010 to 19,944 days in 2012, a 52.4% increase. Additional patient areas will allow ETCH to operate more efficiently and provide better patient care as occupancy increases.

      It appears that the application meets this criterion.

   b. **The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

      ETCH is operating with outdated design spaces and outdated usage which is currently not allowing the facility to operate at maximum efficiency. Portions of ETCH were built in the 1970s, with renovations during the 1980's and 1990's. The current design of the NICU, the surgical areas, and the Neonatal Abstinence Syndrome (NAS) unit does not incorporate patient and family care because the facility was last renovated almost twenty years ago.

      It appears that the application meets this criterion.

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

Tennessee's East Tennessee Children's Hospital (ETCH) is the only freestanding children's hospital in East Tennessee and one of the 5 serving the East Tennessee Perinatal Region. ETCH is one of Tennessee's 5 Regional Perinatal Centers capable of providing Level III obstetric and neonatal care. A full range of services for pediatric patients, including imaging, surgery, pediatric, neonatal intensive care unit (NICU) and Neonatal Abstinence Syndrome (NAS) inpatient beds are available. The hospital's 152 licensed bed complement consist of 79 inpatient pediatric, 60 NICU, and 13 ICU/CCU beds.

The proposed project will consist of the expansion of 211,499 SF of new space and 67,839 SF of renovated space. The primary focus of the renovation and expansion are the NICU, the surgical areas and the NAS unit. ETCH currently has 9 ORs and 3 endoscopy/pulmonology rooms. If approved, the project will include 10 newly constructed operating rooms that will replace the 9 existing ORs (one OR will be added, which will be shelled space), 4 procedure rooms (one procedure room will be added for bronchoscopy procedures), 48 pre-post operating bays to accommodate intake, pre/post-operative care, sterile processing to support surgery and procedure case preparations, 44 private NICU rooms, and 16 private rooms for NAS. A majority of the ETCH ORs are under the current building standard of 400 sq. ft. The new ORs will allow ETCH to meet and exceed current square footage standards for OR and procedure rooms.

The vacated area of the existing NICU will be used for support areas such as respiratory care, family sleep suites, and PICU and NICU support. The vacated surgical areas of the existing 4th floor will be used for a 16 bed NAS unit, rehab area, and shell space. The vacated surgical areas of the existing 6th floor will be used for neurology, child life, social work, a pastoral office, and a laboratory.

Note Agency members: If approved, the applicant is requesting an additional year to complete the project (for a total of 4 years) due to the 2 phases of the project.

- ***Phase 1 (New construction)--Complete the new 211,499 SF building within 2 years (September 23, 2016) and relocate certain services from the existing hospital to the new building***
- ***Phase 2 (Renovation)--Complete the 67,839 SF renovation of the main hospital within 18 months (March 19, 2018). Health Information Management will require temporary relocation to the 3rd floor but no patient areas will be relocated.***

Existing Facility

The next three tables provide an overview of the current beds at ETCH, and how the hospital bed complement will be affected after the proposed renovation and construction.

The following table is the current bed complement of ETCH:

Location	Description of Services	# of inpatient beds	Type of beds
Floor One	Outpatient & Ancillary Support	0	
Floor Two	Medical Services/Outpatient Clinics	37	Private
Floor Three	Medical Services/Clinic/NAS-NICU	42	26 private 16-NICU/NAS private
Floor Four	Outpatient and Inpatient Surgery; Inpatient Beds	16	Private
Floor Five	Neonatal Intensive Care Unit (NICU) & Pediatric Intensive Care Unit (PICU)	57	44 NICU 13 PICU
Floor Six	Perioperative Services	0	
Total beds		152	

Proposed Renovation and Construction

The following two tables reflect renovation at the current facility and construction of the new forty-four bed facility.

Renovation of Existing Facility

Location	Description of Services	# of inpatient beds	Type of beds
Floor One	Outpatient & Ancillary Support	0	
Floor Two	Medical Services	34	Private
Floor Three	Medical Services	30	Private
Floor Four	NAS (NICU) Inpatient Surgery	31	16 NAS Private 15 Private
Floor Five	Pediatric Intensive Care Unit (PICU) and Family Support	13	10 private 3 semi-private
Floor Six	Lab and Neurology and Staff Support	0	
Total beds		108	

Renovation of existing facility

- The renovated third floor will include unit support, an on call suite, satellite pharmacy, lab, and office support areas
- The new NAS unit will be located on the 4th floor
- The 5th floor renovation will include respiratory care, family sleep suites, PICU and NICU support
- The renovated sixth floor will include a neurology lab, laboratory and child life, social work and pastoral areas.

Construction of New Building

Location	Description of Services	# of inpatient beds	Type of beds
Floor One	Shelled Space	0	
Floor Two	Specialty Outpatient Clinic	0	
Floor Three	Perioperative Services	0	
Floor Four	Lockers and Mechanical	0	
Floor Five	NICU	44	Private
Total beds		44	
Total beds after project		152 (108 at existing main hospital + 44 at new building)	

Construction of the new facility:

- The building will total 211,499 SF including 40,900 SF of shelled space for future expansion.
- The new building is proposed to be built in the emergency department parking lot on the south side of White Avenue (please refer to plot plan).
- The upper floors of the new building will bridge over the street to connect the new building with the existing main hospital.
- The floors in the new facility will align and connect to those in the existing hospital on floors 2, 3 and 4.
- The total beds after completion of the proposed project will remain at 152 beds.

Need

The current facility can no longer accommodate necessary growth, updates, or services. ETCH is operating with outdated design spaces. For purposes of this review, need is addressed in the following areas:

NICU

- Family support amenities will reduce the impact on families of extended stays in the hospital
- Private rooms in the NICU will more accommodate family needs by being more home-like with an all-private design and accommodate rooming-in for parents
- The new NICU units will provide better direct patient observation, increased responsiveness and presence of the medical team, and encourage close relationships with family.

Surgical

-Perioperative

- Current perioperative areas are not private and require elevator travel and handoffs with every patient transport.
- Dedicated equipment storage does not exist resulting in surgical corridors being congested and partially blocked.
- The new perioperative design will privatize the surgical experience from intake to discharge and better accommodate families.
- The new forty-eight (48) pre- and post-operative bays will have options for opening up rooms between siblings.

-Operating Rooms and Procedure Rooms

The majority of ETCH's existing operating rooms are under the current building standard of 400 square feet.

- If approved, ETCH will meet and exceed current square footage standards for OR and procedure rooms by having two (2) large ORs (600 SF), eight (8) medium OR's (550 SF) and four (4) procedure rooms (400 SF).

-Neonatal Abstinence Syndrome (NAS) Unit

- A neighborhood design will be incorporated to allow for better patient monitoring and medication provision by shortening distances to the unit support functions.
- The neighborhood design will allow for future phased conversions of NAS into potential medical units, as the occurrence of NAS is anticipated to decline in the future.
- A roof garden will be provided to allow for access to outdoor environments for patient extended stays.

Note to Agency members: ETCH describes NAS as a group of problems that occurs in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb.

An overview of the project is provided in Attachment B-1 of the original application.

Ownership

East Tennessee Children's Hospital is a non-profit entity formed on January 1, 1946. There is no other entity in the ownership structure of the hospital.

Facility Information

- The proposed renovation and expansion will meet or exceed the latest Tennessee Perinatal Care System, Guidelines for Regionalization Hospital Care Levels, and staffing and facilities standards.
- Floor plan drawings are included in Attachment B.IV.
- The Joint Annual Report for 2012 indicates ETCH staffs all 152 licensed beds. Licensed and staffed bed occupancy was 80%.

The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

- *Licensed Beds - The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).*
- *Staffed Beds - The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.*

Service Area Demographics

ETCH's declared service area includes:

-Primary Service Area: Anderson, Blount, Hamblen, Jefferson, Knox, Loudon, Roane and Sevier Counties.

- The total population of the primary service area is estimated at 976,178 residents in calendar year (CY) 2014 increasing by approximately 4.4% to 1,019,044 residents in CY 2018.
- The pediatric population (0-17) of the primary service area is estimated at 204,989 in calendar year (CY) 2014 increasing by approximately 1.1% to 207,241 in CY 2018. Knox County is projected to experience the greatest increase in the 0-17 population in the primary service area from 96,205 in 2014, to 98,645 in 2018, a 2.5% increase.

-**Secondary Service Area**: Campbell, Claiborne, Cocke, Cumberland, Fentress, Grainger, Monroe, Morgan, Pickett, Scott, and Union counties.

- The total population of the secondary service area is estimated at 324,374 residents in calendar year (CY) 2014 increasing by approximately 3.0% to 334,024 residents in CY 2018.
- The pediatric population (0-17) of the secondary service area is estimated at 68,638 in calendar year (CY) 2014 increasing by approximately 3.1% to 70,793 in CY 2018. Cocke County is projected to experience the greatest increase in the 0-17 population in the secondary service area from 8,525 in 2014, to 10,045 in 2018, a 17.8% increase.

-**Tennessee**

- The overall Tennessee statewide 0-17 population is projected to grow by 1.4% from 2014 to 2018.
- The overall Tennessee statewide population is projected to grow by 3.7% from 2014 to 2018.
- The latest 2014 percentage of the population enrolled in the TennCare program is approximately 15.6% in the proposed eight (8) county primary service area, and 23.8% in the secondary eleven (11) county service area, as compared to the statewide enrollment proportion of 18.4%.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Service Area Historical Utilization-NICU

		2010			2011			2012			% increase 10-12
Hospital	Neonatal Intensive Care Bed level	Beds	Days	Occ'y	Beds	Days	Occ'y	Beds	Days	Occ'y	
Tennova-Physician's Regional	NICU,IIB	15	1,337	24.4%	15	1,576	28.8%	15	1,396	25.5%	+4.4%
ETCH	NICU,III-B	44	13,079	81.4%	44	16,038	99.9%	60	19,944	91.1%	+52%
UT Medical	NICU, III-B	62	14,089	62.3%	62	15,580	68.8%	67	15,359	62.8%	+9%
Total		121	28,505	65%	121	33,194	75%	142	36,699	71%	+28.7%

Source: 2010-12 Hospital JARs

- The chart above indicates overall the proposed service area neonatal intensive care bed days have increased an average of 28.7% from 2010 to 2012.
- ETCH has experienced the highest increase in inpatient neonatal patient days in the service area between 2010 and 2012 (52.0%).

**Note to Agency members:*
-Level II-B NICUs are capable of managing more complex maternal and neonatal abnormalities such as care of neonates that require umbilical vessel catheters and protracted mechanical ventilation. In exceptional circumstances, the Level II-B unit may receive patients transferred from Level I and Level II-A institutions.

-Level III NICUs have the capacity to manage the most complex and severe maternal and neonatal illnesses by virtue of their equipment, perinatal staff and on-site availability of a complete spectrum of pediatric sub-specialists. Consultation with specialized physicians elsewhere should rarely be necessary. NICU bed types are defined in the Tennessee Perinatal Care System, Guidelines for Transportation (Fifth Edition).

Applicant's Historical and Projected Utilization
The applicant also provides historical and projected occupancy rate by specialty. Historic and projected trends are displayed in the following table.

	2011	2012	2013	Year One 2017	Year Two 2018
NICU Beds	99.9%	91.1%	91.5%	93%	95%
PICU	43.4%	51.0%	52%	53.5%	55%
Pediatrics	50.7%	63.0%	64%	64.5%	66%

Source: CN1401-002 and 2011-2013 JARs

- The table above indicates the projected occupancy of NICU, PICU, and pediatric bed occupancy will increase slightly from 2013 to 2017 (Year One).

Historical Surgical Volume

If approved, the project will include 10 newly constructed operating rooms (one OR will be added, which will be shelled space) that will be located in 40,172 square feet on level 3 of the new hospital addition. The newly constructed operating suite will replace ETCH's existing 9 ORs and 3 endoscopy/pulmonology rooms located in 34,205 sq. ft. of space on levels 4 and 6 of the existing hospital.

The utilization table below reflects the following:

- There was a 21.2% increase in surgical cases at ETCH from 2010 to 2013.
- The historical surgical volume of ETCH is based on 8 operating rooms.

ETCH
Historical Surgical Utilization

	2010	2011	2012	*2013
Operating Rooms (8)	8,882	9,459	11,290	10,769

Source: Joint Annual Report 2010-2013
**Provisional Joint Annual Report*

Project Cost

Major costs are:

- Construction Costs plus contingencies- $56,948,800 or 76% of total cost.
- Fixed and moveable equipment- $5,983,500, or 8% of the total cost.
- Average renovation cost is expected to be $111.00 per square foot. The renovation cost per square foot is between the 1st quartile of $99.12 and the median cost PSF of $177.60 cost PSF of previously approved hospital projects from 2010-2012.
- Average construction cost is expected to be $224.00 per square foot. The construction cost per square foot is below the 1st quartile of $234.64 of previously approved hospital projects from 2010-2012.
- For other details on Project Cost, see the Project Cost Chart on page 19 of the original application.

Historical Data Chart

- According to the Historical Data Chart, ETCH experienced profitable net operating results for the three most recent years reported: $11,787,543 for 2011; $25,357,874 for 2012; and $26,416,113 for 2013.
- Average Annual Net Operating Income (NOI) was favorable at approximately 6.6% of annual net operating revenue for the year 2013.

Projected Data Chart

- 77,635 patient days are projected in Year 2017 and 78,799 patient days in Year 2018.
- Net operating income less capital expenditures for the proposed project will equal $4,167,924 in Year 2017 increasing to $4,094,193 in Year 2018.

Charges

In Year One of the proposed project, the average charge per case is as follows:

Average Gross Charge

- $6,051

Average Deduction from Operating Revenue

- $3,677

Average Net Charge

- $2,374

Medicare/TennCare Payor Mix

- TennCare/Medicaid-Charges for ETCH will equal $118,000,000 in Year One representing 25% of total gross revenue.
- Medicare- Since the patient population of ETCH are children, Medicare charges are minimal.

Financing

ETCH anticipates that approximately $60 million dollars of the proposed project will be financed through a conduit bond issue and cash reserves.

A letter dated January 10, 2014 from the Health, Educational and Housing Facility Board of the County of Knox documents favorable contact of financing the proposed project through a conduit bond issue. According to the IRS, a conduit bond issue is a situation where tax-exempt bonds are issued by a state or local government and the proceeds are used for a defined qualified purpose by the entity other than the government issuing the bonds. A letter dated January 10, 2014 from Ponder and Company anticipates that ETCH will receive an investment grade bond rating of "Baa1" from Moody's Investors Services and "BBB+" from Standard and Poor's Corporation.

Per Standard and Poor's web-site, an obligation rated 'BBB' is considered adequate capacity to meet financial commitments, but is more subject to adverse economic conditions. Moody's web-site defines the global long-term credit rating for "Baa1" as judged to be medium-grade and subject to moderate credit risk and as such may possess certain speculative characteristics.

An August 21, 2013 letter from Zane Goodrich, ETCH's Chief Financial Officer, confirms the applicant has sufficient cash reserves of $150,535,070 in cash, cash equivalents, and trading securities to finance the cash portion of the proposed project.

ETCH's audited financial statements for the period ending June 30, 2013 indicates $32,461,421 in cash and cash equivalents, total current assets of $67,245,911, total current liabilities of $24,979,913 and a current ratio of 2.70:1.

Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Staffing

The applicant does not anticipate needing additional staff as a result of this project. The direct patient staffing for the proposed project is presented in the following table:

Unit	RN	LPN	Tech/CNA	Total
NICU	108	4	25	137
OR	22	1	22	45
PACU	12	0	2	14
OPS	14	0	5	19
Total	**156**	**5**	**54**	**215**

Licensure/Accreditation

ETCH is licensed by the Tennessee Department of Health, Division of Health Care Facilities.

ETCH is accredited by The Joint Commission with an accreditation cycle effective July 28, 2012 valid for up to thirty-six (36) months. A report from The Joint Commission for the survey dated 11/06/2012-11/08/2012 is included in Attachment 15, Contribution to the Orderly Development of Healthcare 7.b in the 1st supplemental response.

Corporate documentation, real estate deed information, performance improvement plan, utilization review plan, and patient bill of rights are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in **four** years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, denied, pending applications, or outstanding Certificates of Need for this applicant.

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied, pending applications, or outstanding Certificates of Need, for other health care organizations proposing this type of service.

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME (4/2/14)

LETTER OF INTENT

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Knoxville News Sentinel (Name of Newspaper) which is a newspaper of general circulation in Knox (County), Tennessee, on or before January 10 (Month/Day), 20 14 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

East Tennessee Children's Hospital (Name of Applicant) Hospital (Facility Type-Existing)

owned by: East Tennessee Children's Hospital Association, Inc. with an ownership type of non-profit corporation

and to be managed by: itself intends to file an application for a Certificate of Need

for: renovation and expansion of the NICU, Neonatal Abstinence Syndrome Unit, Perioperative Services, and Specialty Clinic located on the Hospital's campus at 2018 Clinch Avenue, Knoxville, TN 37916. The licensed beds are not affected, no services will be initiated, and no major medical equipment will be purchased as a result of this project. The estimated project costs are $75,300,000.

The anticipated date of filing the application is: January 15, 20 14

The contact person for this project is Kim Harvey Looney (Contact Name), Attorney (Title)

who may be reached at: Waller Lansden Dortch & Davis LLP (Company Name), 511 Union Street, Suite 2700 (Address)

Nashville (City), TN (State), 37219 (Zip Code), 615 (Area Code) / 850-8722 (Phone Number)

Kim H. Looney (Signature), 1-10-14 (Date), Kim.Looney@wallerlaw.com (Email-Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

COPY

-Application

East Tennessee Children's Hosp.

CN1401-002

1. ***Name of Facility, Agency, or Institution***

East Tennessee Children's Hospital
Name
2018 Clinch Avenue
Street or Route
Knoxville
City
TN
State
Knox
County
37916
Zip Code

2. ***Contact Person Available for Responses to Questions***

Kim H. Looney
Name
Attorney
Title
Waller Lansden Dortch & Davis LLP
Company Name
kim.looney@wallerlaw.com
Email address
511 Union Street; Suite 2700
Street or Route
Nashville
City
TN
State
37219
Zip Code

Attorney
Association with Owner
615-850-8722
Phone Number
615-244-6804
Fax Number

3. ***Owner of the Facility, Agency or Institution***

East Tennessee Children's Hospital Association, Inc.
Name
865-541-8000
Phone Number
2018 Clinch Avenue
Street or Route
Knox
County
Knoxville
City
TN
State
37916
Zip Code

4. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship	____	F.	Government (State of TN or Political Subdivision)	____
B.	Partnership	____	G.	Joint Venture	____
C.	Limited Partnership	____	H.	Limited Liability Company	____
D.	Corporation (For Profit)	____	I.	Other (Specify) ____	____
E.	Corporation (Not-for-Profit) X				

Response: Since the hospital is a non-profit corporation, there is no other entity in the ownership structure of the hospital.

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

Response: Please see organization documents included as Attachment A-3.

5. ***Name of Management/Operating Entity*** *(If Applicable)*

N/A
Name

Street or Route | County

City | State | Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution*** *(Check One)*

A.	Ownership	X	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify) _____	
C.	Lease of _____ Years				

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

Response: Please see deed included as Attachment A-6.

7. ***Type of Institution*** *(Check as appropriate--more than one response may apply)*

A.	Hospital (Specify) _____	X	I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		K.	Recuperation Center	
D.	Home Health Agency		L.	Rehabilitation Facility	
E.	Hospice		M.	Residential Hospice	
F.	Mental Health Hospital		N.	Non-Residential Methadone Facility	
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		P.	Other Outpatient Facility (Specify) _____	
			Q.	Other (Specify) _____	

8. ***Purpose of Review*** *(Check) as appropriate--more than one response may apply)*

A.	New Institution		G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility	X			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) _____		H.	Change of Location	
			I.	Other (Specify) _____	
E.	Discontinuance of OB Services				
F.	Acquisition of Equipment				

9. **Bed Complement Data**
Please indicate current and proposed distribution and certification of facility beds.

	Current Beds Licensed	Current Beds *CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A. Medical					
B. Surgical					
C. Long-Term Care Hospital					
D. Obstetrical					
E. ICU/CCU	13			0	13
F. Neonatal	60			0	60
G. Pediatric	79			0	79
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolescent Psychiatric					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid Certified)					
M. Nursing Facility Level 1 (Medicaid only)					
N. Nursing Facility Level 2 (Medicare only)					
O. Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child and Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	152			0	152

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** 44-3303
Certification Type hospital

11. **Medicaid Provider Number** 0443303
Certification Type hospital

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** N/A

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants?** YES **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

Response: Blue Care, which includes TennCare Select, United Health Care Community Plan, and AmeriGroup

Discuss any out-of-network relationships in place with MCOs/BHOs in the area. N/A

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response: See Attachment B, Project Description, I for a copy of the Executive Summary.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

Response: East Tennessee Children's Hospital (ETCH) is the only freestanding children's hospital serving the East Tennessee Perinatal Region. It was the first certified Comprehensive Regional Pediatric Center (CRPC) in Tennessee, which is the highest level of certification for pediatric care. The current facility is landlocked, with no remaining vertical building options, so that horizontal expansion is needed to update existing services and encourage the development of new programs. An

extensive master planning effort was undertaken in 2012, in order to complete programming and conceptual design for a building expansion to the existing facility. The applicant plans to build 211,499 square feet of new space and renovate 67,839 of existing space. The best site for the new building is the emergency department parking lot on the south side of White Avenue. The upper floors of the new building will bridge over the street to connect the new building to the existing main hospital. The expansion is planned to accommodate the renovation and expansion and relocation of the NICU and Neonatal Abstinence Syndrome (NAS) areas, as well as to consolidate the perioperative services on one floor. There will be no new beds as a result of this expansion, but the areas need to be expanded to allow for best practices in pediatric care. It is expected that the new floors will align and connect to those in the existing hospital on floors 2, 3 and 5. The renovation and expansion will include the following:

- 10 operating rooms and 4 procedure rooms: 2 large ORs (600 square feet), 8 medium ORs (500 square feet) and 4 procedure rooms (400 square feet)
- 48 Pre/Post Op bays to accommodate intake, pre- and post-operative care of both inpatients and outpatients in private settings, with options for opening up rooms between siblings
- Sterile processing to support surgery and procedure case preparations
- 44 private NICU rooms (including 4 twin rooms) on Level 5
- 16 private NICU rooms for NAS services to be located on Level 4 of the existing hospital, designed to the level of an ICU

Current ETCH facilities are at capacity. Over time, many family spaces in patient and public areas have been reduced or displaced to serve medical purposes. In some instances, the concept of patient and family centered care was not even incorporated into the planning, because the space was built so long ago. Portions of ETCH were built in the 1970's. Renovations occurred in the 1980's and again in the 1990's but these renovations are outdated as well. The facility is operating with outdated design spaces and outdated usage, which does not allow it to operate at maximum efficiency. The facility can no longer accommodate necessary growth, updates or services. Children's hospitals have changed significantly since ETCH was built and any renovations were completed. Programs should not only focus on the health of the child, but should incorporate the family in patient care. The areas that are the primary focus of the renovation and expansion are the NICU, the surgical areas, and the NAS unit.

In the NICU, having private rooms will help meet the family's needs for sleeping accommodations while being present 24/7 in a more home-like environment, as compared to the current open layout. The all-private room design will accommodate rooming-in for parents with a sofa bed, storage space for family, and most importantly a controlled environment for the baby and mother. References and research materials for family members during the stay are housed in the resource room which acts as a small library and business center. This, in turn, will enhance parent education in preparation for being discharged. Family support amenities will be enhanced to reduce the impact of extended stays. The unit's

family lounge will help parents during their stay by supplying a kitchen, showers, and laundry facilities. Along with decentralized stations, the new units will provide better direct observation of patients, increased responsiveness and presence of the medical team, and encourage closer relationships with the family.

The current Perioperative Services at ETCH are located on two levels: Floor 4 is Intake and Phase 2 Recovery, and Floor 6 is Pre-Op Holding, Surgery and Phase I Recovery (PACU). This bifurcated system is the result of growth without proper spatial accommodations, and requires elevator travel and handoffs with every patient transport. Patient spaces are not private, which is the current standard. Dedicated equipment storage is nonexistent, so surgical corridors are congested and partially blocked. The new PeriOp space will be radically changed. In PeriOp, the adaptable Pre-Post Op room will privatize the surgical experience, from intake to discharge. Unlike the curtained units of the past, the new model will provide acoustical abatement and visual privacy between adjacent occupants, while the decentralized workstation and break-away glass doors will help maintain constant visual access between, and among, patients and the care team. Inside, these rooms will be sized and zoned to accommodate families on one side of the patient, and caregivers on the other. Peri-operative histories, as well as exams and detailed post-operative care instructions, will be given in a private setting without disruption or intrusion. Keeping family informed of their child's progression through surgery, by means of tracking boards in designated public spaces, will allow families the freedom to leave the waiting room and alleviate potential anxiety and stress. Families will be notified when to be present for a post-op meeting with the surgeon/proceduralist, to be conducted in a private room, with comfortable furniture and media to illustrate the measures taken with each case. This project includes 48 pre- and post-operative bays to accommodate intake and pre- and post-operative care of both inpatients and outpatients in private settings, with options for opening up rooms between siblings.

The applicant currently operates three (3) endoscopy/pulmonology rooms and nine (9) operating rooms. It will add one (1) procedure room in order to have a dedicated negative room to perform bronchoscopy procedures. In addition, it will have shelled space for one operating room for future expansion. The majority of the current operating and procedure rooms are only 330 square feet. None are at usable square footage of 400 square feet, which is the current building standard for operating rooms. The applicant plans to have 2 large ORs (600 square feet), 8 medium ORs (500 square feet) and 4 procedure rooms (400 square feet).

The new NAS unit will be located on Floor 4 of the existing hospital building. The NAS population needs constant medication and supervision. Each of the patient rooms has an individual toilet and is similar in size to the NICU patient room. The neighborhood design allows for better patient monitoring and medication provision by shortening distances to the unit support functions. This neighborhood design also allows for future phased conversions of NAS into potential medical units, as the NAS baby occurrence is anticipated to decline. A roof garden is provided to allow for access to outdoor environments for the patient during their extended stay.

The applicant plans to build the new building first. This building is expected to include 211,499 square feet, including 40,900 square feet of shelled space for future expansion, and take approximately 2 years to build. It will be five stories tall,

and will connect to the existing building on floors 2, 3 and 5. A portion of the shelled space will be used for future outpatient clinics and space for support programs. It is anticipated that construction of the new building will take place over a two-year period. After the new building is complete and operational, certain services in the existing building will be relocated to the new building. As renovation begins, the health information management area on the ground floor will be temporarily relocated to the 3rd floor. No patient areas will require temporary relocation as a result of this project, which is unusual for a project of this size. The renovation portion of the project is expected to impact 67,839 square feet and take 18 months for completion.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response: There is no increase in beds as a result of this project. To the extent beds are relocated, this aspect of the project is described in response to Section B, Project Description, IIA above.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Material Management	Level 0	2,250	N/A	Level 0, 2	4,337	-	4,337	$85	$0	$85
Central Supplies	Level 0	1,500	N/A	Level 0	1,740	-	1,740	$85	$0	$85
LEAN	Level 0	115	N/A	Level 0	631	-	631	$65	$0	$65
Shell Renovations	N/A	N/A	N/A	Level 1,3,6	6,450	-	6,450	$10	$0	$10
Family Resource	Level 1	185	N/A	Level 1	512	-	512	$75	$0	$75
Gift Shop Expansion	Level 1	910	N/A	Level 1	216	-	216	$50	$0	$50
HIM	Level 0	1,750	N/A	Level 1	2,442	-	2,442	$85	$0	$85
Phlebotomy Expansion	Level 1	845	N/A	Level 1	1,055	-	1,055	$100	$0	$100
Pulmonary Expansion	Level 1	710	N/A	Level 1	1,123	-	1,123	$115	$0	$115
Radiology Expansion & Renovation	Level 1	9,200	N/A	Level 1	2,119	-	2,119	$150	$0	$150
Sedation & Procedure	Level 1	740	N/A	Level 1	870	-	870	$130	$0	$130
Connection	N/A	N/A	N/A	Level 2	75	-	75	$75	$0	$75
On-Call Suite	N/A	N/A	N/A	Level 3	1,038	-	1,038	$200	$0	$200
Physician Lounge (Hospitalist)	Level 0	490	N/A	Level 3	219	-	219	$150	$0	$150
CPG Suite	Level 3	225	N/A	Level 3	668	-	668	$100	$0	$90
Satellite Pharmacy	N/A	N/A	N/A	Level 3	638	-	638	$175	$0	$175
Med Surgery Support	Level 3		N/A	Level 3	476	-	476	$85	$0	$85
NAS	Level 3	12,180	N/A	Level 4	10,281	-	10,281	$150	$0	$150
Rehab	Level 4	930	N/A	Level 4	717	-	717	$125	$0	$125
Family Sleep Suite	N/A	N/A	N/A	Level 5	1,877	-	1,877	$250	$0	$250

EVS-Laundry-Family Sleep Suite	N/A	N/A	N/A	Level 5	230	-	230	$50	$0	$50
Chapel	Level 1	230	N/A	Level 5	468	-	468	$100	$0	$100
CPG (Intensivist) Offices	Level 5	985	N/A	Level 5	752	-	752	$90	$0	$100
Formula Lab	Level 5	80	N/A	Level 5	684	-	684	$150	$0	$150
Respiratory Care	Level 2,3,5	1,770	N/A	Level 5	1,991	-	1,991	$150	$0	$150
PICU Support	Level 5	380	N/A	Level 5	1,738	-	1,738	$150	$0	$150
Coordinator Offices	Level 2,3,4,5	N/A	N/A	Level 6	809	-	809	$75	$0	$75
Neurology	Level 1	2,440	N/A	Level 6	4,513	-	4,513	$150	$0	$150
Child Life, Social Work, Pastoral Office	MOB Level 2	N/A		Level 6	3,685	-	3,685	$85	$0	$85
Laboratory/Blood Bank	Level 1	4,395	N/A	Level 6	7,109	-	7,109	$150	$0	$150
NICU	Level 5	13,025	N/A	Level 5	603	31,432	32,035	$100	$350	$345
Surgery	Level 4,6	34,205	N/A	Level 3	-	40,172	40,172	$0	$370	$370
Central Sterille	Level 0,6	2,400	N/A	Level 2	-	5,820	5,820	$0	$300	$300
Specialty Clinic	Level 3	7,000	N/A	Level 2	-	11,173	11,173	$0	$200	$200
IV IG Suite	N/A	N/A	N/A	Level 2	-	2,331	2,331	$0	$150	$150
Shell	N/A	N/A	N/A	Level 4,3,2	-	40,884	40,884	$0	$125	$125
Café	N/A	N/A	N/A	Level 2	-	1,692	1,692	$0	$200	$200
Support (Public Toilet, JC)	N/A	N/A	N/A	Level 3,5,6	1,303	657	1,960	$100	$150	$117
Materials Management (Expansion)	N/A	N/A	N/A	Level P1,2	-	1,503	1,503	$0	$200	$200
EVS (Expansion)-Laundry	N/A	N/A	N/A	Level 2	-	312	312	$0	$75	$75
B. Unit/Depart. GSF Sub-Total		98,940			61,369	135,976	197,345			$219
C. Mechanical/ Electrical GSF		N/A		All Levels	-	46,499	46,499	$0	$150	$150
D. Circulation/ Structure GSF		6,470		All Levels	6,470	29,024	35,494	$50	$150	$132
E. Total GSF		105,410			67,839	211,499	279,338	$111.00*	$224.00*	$197.0

* This is the average cost per square foot.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

Response: Not applicable. No health care services are being initiated in this project.

D. Describe the need to change location or replace an existing facility.

Response: Not applicable. This is not a relocation or replacement project.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

   a. Describe the new equipment, including:

      1. Total cost ;(As defined by Agency Rule).
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval.

   Response: Not applicable.

   b. Provide current and proposed schedules of operations.

   Response: Not applicable.

2. For mobile major medical equipment:

   a. List all sites that will be served;

   b. Provide current and/or proposed schedule of operations;

   c. Provide the lease or contract cost.

   d. Provide the fair market value of the equipment; and

   e. List the owner for the equipment.

   Response: Not applicable.

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

   Response: Not applicable.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

Response: The size of the site is 2.85 acres. Please see a copy of the plot plan included in Attachment B-Project Description-III(A).

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: The site is readily accessible to patients/clients. Cumberland Avenue, one of the main thoroughfares in Knoxville, is located one block from the south side of the hospital campus. It has regular bus service with stops close to the hospital.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

Response: Please see attached floor plan drawings included in Attachment B-Project Description-IV.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

RESPONSE: Not applicable. This application is not for a home care organization.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

      Response: Following are the criteria for the renovation or expansion of an existing health care institution.

   Need:

   1. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

      Response: The applicant is not adding beds but is working to right size the facility to meet the needs of the existing standard of care for children's hospitals. As is seen in the utilization tables included in response to Sections C-Need-5 and C-Need-6, ETCH is currently operating at a high level of capacity. The ability to add

additional patient areas will allow the facility to operate more efficiently and provide better patient care. ETCH is the only freestanding children's hospital in the East Tennessee Perinatal Region.

2. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Response: Current ETCH facilities are at capacity. Over time, many family spaces in patient and public areas have been reduced or displaced to serve medical purposes. In some instances, the concept of patient and family centered care was not even incorporated into the planning, because the space was built so long ago. Portions of ETCH were built in the 1970's. Renovations occurred in the 1980's and again in the 1990's but these renovations are outdated as well. The facility is operating with outdated design spaces and outdated usage, which does not allow it to operate at maximum efficiency. The facility can no longer accommodate necessary growth, updates or services. Children's hospitals have changed significantly since that time. Programs should not only focus on the health of the child, but should incorporate the family in patient care. The areas that are the primary focus of the renovation and expansion are the NICU, the surgical areas, and the Neonatal Abstinence Syndrome (NAS) unit.

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

Response: Not applicable. This application is not for a Change of Site.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response: The project is consistent with the facility's long-range development plan, which was most recently updated in 2012.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

Response: The primary service area for the applicant includes Anderson County, Blount County, Hamblen County, Jefferson County, Knox County, Loudon County, Roane County, and Sevier County. This area comprises over 70% of the patient origin for ETCH. Its secondary service area includes the remainder of the 19 county East Tennessee Perinatal Region. Please see map included as Attachment C-Need-3.

4. A. Describe the demographics of the population to be served by this proposal.

Response: Below is a table showing the demographics of the population to be served. The table compares the primary service area to the entire East Tennessee Perinatal Region and to the State as a whole. The population for the primary service area is 976,178 persons, 324,374 persons for the secondary service area for a total service area population of 1,300,552 in 2014. The primary service area population is expected to increase 4.4% from 2014 to 2018 and the total service

area is expected to increase 4.0% from 2014 to 2018. The population for the State of Tennessee is expected to increase 3.7% during this same time period.

Population Estimates
2014

Age	Primary Service Area	Secondary Service Area	Total Service Area	State of Tennessee
0-4	54,486	17,528	72,014	401,571
5-9	55,496	19,354	74,850	419,628
10-14	58,749	19,759	78,508	426,430
15-19	62,151	19,675	81,826	428,957
20-44	308,589	95,202	403,791	2,172,095
45-64	270,522	88,707	359,229	1,758,033
65+	166,185	64,149	230,334	981,984
TOTAL	976,178	324,374	1,300,552	6,588,698

Source: TDH Population Projections, June 2013

Population Projections
2018

Age	Primary Service Area	Secondary Service Area	Total Service Area	State of Tennessee
0-4	57,683	19,170	76,853	413,432
5-9	54,558	19,485	74,043	416,944
10-14	58,145	20,156	78,301	433,217
15-19	63,596	20,446	84,042	443,997
20-44	313,884	99,355	413,239	2,213,167
45-64	281,431	86,962	368,393	1,810,339
65+	189,757	68,450	258,207	1,102,413
TOTAL	1,019,044	334,024	1,353,068	6,833,509

Source: TDH Population Projections, June 2013

Percent Increase (Decrease)
2014-2018

Age	Primary Service Area	Secondary Service Area	Total Service Area	State of Tennessee
0-4	5.9	9.4	6.7	3.0
5-9	(1.7)	0.7	(1.1)	(0.6)
10-14	(1.0)	2.0	(0.3)	1.6
15-19	2.3	3.9	2.7	3.5
20-44	1.7	4.4	2.3	1.9
45-64	4.0	(2.0)	2.6	3.0
65+	14.2	6.7	12.1	12.3
TOTAL	4.4	3.0	4.0	3.7

The following table shows certain demographic characteristics for the primary service area, the total service area, and the State of Tennessee. Shown is the population for women aged 15-44, the primary child bearing age, the median household income, and TennCare enrollees. The percentage of women aged 15-44 is very similar to the percentage of women in the State of Tennessee. The median household income is lower in both the primary service area and the total service area than the State of Tennessee. The percentage of persons enrolled in TennCare is slightly higher in the primary service area and slightly lower in the total service area than in the State of Tennessee.

DEMOGRAPHIC CHARACTERISTICS

Demographic	Primary Service Area	Total Service Area	State of Tennessee
Women Age 15-44 Population—2014	184,651	241,084	1,301,018
% of Population	19.1%	18.6%	19.7%
Women Age 15-44 Population—2018	187,578	246,482	1,326,526
% of Population	18.5%	18.4%	19.4%
Women Age 15-44 % Change 2014-2018	1.6%	2.2%	2.0%
Median Household Income	$43,976	$37,522	$44,140
TennCare Enrollees (09/13)	150,688	227,731	1,198,663
Percent of 2013 Population Enrolled in TennCare	17.4%	19.1%	18.4%

Source: TDH Population Projections, June 2013; U.S. Census QuickFacts and FactFinder 2; TennCare Bureau

A significant amount of the population in the primary and secondary service areas is below the federal poverty line. The percentage in the primary service area ranges from 13.4% to 19.2%, and the percentage in the secondary service area ranges from 16.4% to 25.8%. The average for the state of Tennessee is 17.3 %. All but 2 counties in the primary service area are better than the average for the state of Tennessee, but only 1 county in the remainder of the East Tennessee Perinatal Region is better than the average for the state of Tennessee.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: The applicant provides access to the fragile young population, and women, because it is a children's hospital. It serves low-income groups in that approximately 60% of its patient population is on TennCare. ETCH is requesting approval for this project so that it can better meet the needs of these patient populations.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to

list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: The table below provides size and utilization data for all existing and approved Level II-B or higher NICU units in the 19-county East Tennessee Perinatal Region. As the information demonstrates, the services provided by ETCH are full, with an occupancy rate of 91.1 % for its NICU beds in 2012. The other facility in the area providing III-B services, is the University of Tennessee and its occupancy in 2012 is 62.8%. There are 142 Level II-B or higher NICU beds in the East Tennessee Perinatal Region, 127 Level III-B and 15 Level II-B, and all are located in Knoxville. UT is the only other facility that has PICU beds. In 2012, the utilization of PICU beds for ETCH was 51.0% and for UT was 22.7%.

Utilization of Neonatal Intensive Care Beds (Levels II-B & III-B) and Pediatric Intensive Care Beds

Hospital	2010				2011				2012			
	Reported Beds	Days	ADC	Occ'y	Reported Beds	Days	ADC	Occ'y	Reported Beds	Days	ADC	Occ'y
Tennova Healthcare												
NICU, II-B	15	1,337	3.7	24.4%	15	1,576	4.3	28.8%	15	1,396	3.8	25.5%
ETCH												
NICU, III-B	44	13,079	35.8	81.4%	44	16,038	43.9	99.9%	60	19,944	54.6	91.1%
UT Medical												
NICU, III-B	62	14,089	38.6	62.3%	62	15,580	42.7	68.8%	67	15,359	42.1	62.8%

Source: Tennessee Department of Health Joint Annual Reports 2010-2012.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: The following tables provide historical and projected bed utilization data for the applicant. The applicant is working hard to reduce the incidence of NAS, which would allow for increased utilization for other NICU patient populations.

ETCH OCCUPANCY RATE HISTORICAL AND PROJECTED

	2011	2012	2013	2017	2018
NICU Beds	99.9%	91.1%	91.5%	93%	95%
PICU	43.4%	51.0%	52%	53.5%	55%
Pediatrics	50.7%	63.0%	64.0%	64.5%	66%

Source: Tennessee Department of Health Joint Annual Reports 2010-2012 and East Tennessee Children's Hospital 2013 hospital data.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)

   - The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

   - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

   - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

     Response: Please see the project costs chart on the following page. Please see letter from the contractor included as Attachment C-Economic Feasibility, 1. The contractor's estimate of construction costs includes the cost for a parking deck, which are not required to be included as a part of this project. Therefore, the cost for the 57,000 square foot parking deck of $4,840,240 is not included in the Project Costs Chart. Given the size and scope of this project, these costs are reasonable.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$ 4,155,000
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$ 922,000
	3.	Acquisition of Site	
	4.	Preparation of Site	$ 2,147,700
	5.	Construction Costs	$55,088,800
	6.	Contingency Fund	$ 1,860,000
	7.	Fixed Equipment (Not included in Construction Contract)	$ 5,080,400
	8.	Moveable Equipment (List all equipment over $50,000 - N/A)	$ 903,100
	9.	Other (Specify) Moving expenses	$ 200,000
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify) _____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	$ 1,200,000
	3.	Reserve for One Year's Debt Service	$ 3,700,000
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		$75,257,000
E.	CON Filing Fee		$ 45,000
F.	Total Estimated Project Cost (D+E)	TOTAL	$75,302,000

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

☐ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

☒ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

☐ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

☐ D. Grants--Notification of intent form for grant application or notice of grant award; or

☒ E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

☐ F. Other—Identify and document funding from all other sources.

Response: The applicant anticipates funding the project from a combination of the issuance of bonds and cash reserves. Please see Attachment C-Economic Feasibility-2 for letters from Zane Goodrich, Vice President for Finance and Chief Financial Officer, East Tennessee Children's Hospital; The Chair of The Health, Educational, and Housing Facility Board of the County of Knox, and John E. Cheney, Senior Vice President of Ponder and Company, which anticipates providing the financing for the bonds.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

Response: Hospital construction projects approved by the HSDA from 2010-2012 had the following construction cost per square foot:

HOSPITAL CONSTRUCTION COST PSF
2010-2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12	$234.64	$167.99
Median	$177.60	$259.66	$235.00
3rd Quartile	$249.00	$307.80	$274.63

Source: HSDA website—Cost per square foot ranges-construction.

This hospital construction project will have the following construction cost per square foot. The numbers are rounded to the nearest whole number.

EAST TENNESSEE CHILDREN'S HOSPITAL
CONSTRUCTION COSTS

	Renovation	New Construction	Total Project
Square Feet	67,839	211,499	279,338
Construction Cost	$7,528,785	$47,394,990	$54,923,775
Construction Cost Per Square Foot	$111.00	$224.00	$197.00

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response: Please see Historical and Projected Data Charts on the following pages.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in June.

	Year 2013	Year 2012	Year 2011
A. Utilization Data (Specify unit of measure) Adjusted patient days	75,383	72,725	70,890
B. Revenue from Services to Patients			
1. Inpatient Services	$222,826,251	$216,304,313	$178,495,814
2. Outpatient Services	$159,272,338	$147,676,412	$143,882,284
3. Emergency Services	$33,636,507	$26,369,350	$29,678,387
4. Other Operating Revenue-parking, cafeteria, gift shop, etc.	$5,850,203	$3,600,050	$3,474,883
Gross Operating Revenue	**$421,585,299**	**$393,950,125**	**$355,531,368**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$229,031,006	$209,936,056	$197,256,126
2. Provision for Charity Care	$962,359	$1,131,609	$948,000
3. Provisions for Bad Debt	$3,691,343	$4,110,085	$3,927,046
Total Deductions	**$233,684,708**	**$215,177,750**	**$202,131,172**
NET OPERATING REVENUE	**$187,900,591**	**$178,772,375**	**$153,400,196**
D. Operating Expenses			
1. Salaries and Wages	$75,246,800	$72,161,335	$65,396,820
2. Physician's Salaries and Wages	$4,745,894	$3,085,265	$2,260,294
3. Supplies	$26,936,735	$24,636,401	$21,718,340
4. Taxes	$489,637	$508,139	$451,085
5. Depreciation	$7,666,801	$7,175,490	$6,650,391
6. Rent	$308,341	$298,341	$191,507
7. Interest, other than Capital	$2,181,202	$2,254,639	$2,275,668
8. Management Fees:			
a. Fees to Affiliates	-0-	-0-	-0-
b. Fees to Non-Affiliates	-0-	-0-	-0-
9. Other Expenses – Specify on separate page 12	$41,668,070	$39,482,479	$37,053,083
Total Operating Expenses	**$159,243,480**	**$149,602,089**	**$135,997,188**
E. Other Revenue (Expenses) – Net (Specify) Physician Expense	$1,140,998	$2,762,412	$4,610,465
NET OPERATING INCOME (LOSS)	**$27,516,113**	**$26,407,874**	**$12,792,543**
F. Capital Expenditures			
1. Retirement of Principal	$1,100,000	$1,050,000	$1,005,000
2. Interest	-0-	-0-	-0-
Total Capital Expenditures	**$1,100,000**	**$1,050,000**	**$1,005,000**
NET OPERATING INCOME (LOSS)	**$27,516,113**	**$26,407,874**	**$12,792,543**
LESS CAPITAL EXPENDITURES	**$26,416,113**	**$25,357,874**	**$11,787,543**

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in June.

		Year 2017	Year 2018
A.	Utilization Data (Specify unit of measure) Adjusted Patient Days	77,635	78,799
B.	Revenue from Services to Patients		
1.	Inpatient Services	$247,282,982	$258,521,993
2.	Outpatient Services	$181,199,957	$195,122,856
3.	Emergency Services	$37,303,977	$38,999,442
4.	Other Operating Revenue (Specify) parking, cafeteria, gift shop, etc.	$3,984,403	$4,044,169
	Gross Operating Revenue	**$469,771,319**	**$496,688,460**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$278,480,646	$297,496,437
2.	Provision for Charity Care	$1,397,361	$1,477,933
3.	Provisions for Bad Debt	$5,589,443	$5,911,732
	Total Deductions	**$285,467,450**	**$304,886,102**
	NET OPERATING REVENUE	**$184,303,869**	**$191,802,358**
D.	Operating Expenses		
1.	Salaries and Wages	$83,724,444	$85,598,433
2.	Physician's Salaries and Wages	$5,300,565	$5,406,576
3.	Supplies	$31,504,246	$33,309,388
4.	Taxes	$489,113	$489,113
5.	Depreciation	$9,442,547	$11,888,976
6.	Rent	$350,048	$357,049
7.	Interest, other than Capital	$1,602,300	$3,560,000
8.	Management Fees:		
	a. Fees to Affiliates	-0-	-0-
	b. Fees to Non-Affiliates	-0-	-0-
9.	Other Expenses – Specify on separate page 12	$42,427,227	$43,739,520
	Total Operating Expenses	**$174,840,490**	**$184,349,055**
E.	Other Revenue (Expenses) -- Net (Specify) Physician Expense	$1,067,755	$1,089,110
	NET OPERATING INCOME (LOSS)	**$8,395,624**	**$6,364,193**
F.	Capital Expenditures		
1.	Retirement of Principal	$2,110,000	$2,270,000
2.	Interest	$2,117,700	-0-
	Total Capital Expenditures	$4,227,700	**$2,270,000**
	NET OPERATING INCOME (LOSS)	**$8,395,624**	**$6,364,193**
	LESS CAPITAL EXPENDITURES	**$4,167,924**	**$4,094,193**

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2013	Year 2012	Year 2011
1. Employee Benefits	$21,924,378	$21,267,202	$19,353,084
2. Professional Fees	$9,726,173	$9,134,075	$8,761,189
3. Utilities and Insurance	$3,956,437	$3,945,371	$3,834,870
4. Repairs and Service	$4,342,084	$3,962,307	$3,886,546
5. Interest	-0-	-0-	-0-
6. Education and Dues	$1,414,347	$811,040	$927,390
7. Other	$304,651	$362,484	$290,004
Total Other Expenses	**$41,668,070**	**$39,482,479**	**$37,053,083**

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2017	Year 2018
1. Employee Benefits	$23,442,844	$23,967,561
2. Professional Fees	$8,057,871	$8,219,028
3. Utilities and Insurance	$4,500,898	$5,590,916
4. Repairs and Service	$5,014,235	$4,514,235
5. Interest	$-0-	$-0-
6. Education and Dues	$1,177,093	$1,200,635
7. Other	$234,286	$247,145
Total Other Expenses	**$42,427,227**	**$43,739,520**

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: The project's average gross charge is approximately $6,050 per adjusted patient day, the average deduction from operating revenue is approximately $3,680 per adjusted patient day, and the average net charge is $2,370 per adjusted patient day the first year of operation. Adjusted patient days include volume for both outpatient and emergency department services. The current inpatient average gross charge is $5,721 per inpatient day, with the average deduction from operating revenue of $3,381 per inpatient day, and the average net charge is $2,340 per inpatient day.

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: The applicant does not anticipate any changes to charges as a result of this project. The room rates for ETCH are as follows:

Pediatric Beds:	$1,923 per day
NICU:	$5,387 per day
PICU:	$5,894 per day

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Since this is a freestanding children's hospital, there are no similar facilities in the service area and no recently approved projects that are comparable.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: The applicant has projected a minimal increase of 2-5% in utilization rates, which as the facility is already operating at a high utilization rate, will be sufficient to maintain cost-effectiveness.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response: The applicant anticipates having net operating income of slightly over $8,000,000 the first year of operation and slightly over $6,000,000 the second year of operation, so that financial viability will be ensured within two years. ETCH currently has sufficient cash reserves to offset the operating capital required during the start-up phase of the project. See Attachment C-Economic Feasibility-2.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response: The applicant anticipates that approximately 1% or $1,397,361 of its net operating revenue is for charity care and 64% or $118,000,000 of its net operating revenue is for Medicaid/TennCare in the first year of operation. As ETCH is a children's hospital, any revenue from Medicare is minimal.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response: Please see copies of the balance sheet and the income statement included as Attachment C, Economic Feasibility-10.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response: The applicant has worked hard with its architect and contractor to accomplish the goals of this project in the most cost efficient manner. It feels that it has done the best job it can and that there are no less costly, more effective or more efficient alternatives to the new building that is planned. The hospital does currently have private rooms for most areas and the operating rooms are smaller than those currently being built for new hospital construction. Given the space constraints of the current building it is not possible to expand the ORs; the only option is to build new ORs. The space is also necessary to provide the optimal private space necessary for families of surgical patients.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response: The applicant is unable to accomplish what needs to be accomplished with renovation of space alone. In order to have the facility be brought up to current standards for children's hospitals, it is necessary to add the significant space that is being added.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

   Response: ETCH is designated as a comprehensive regional pediatric center (CRPC) by the state, and as such, is required to have transfer agreements will all hospitals in the region.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

   Response: Only positive effects on the health care system occur as a result of this project. ETCH is the only freestanding children's hospital in the East Tennessee Perinatal Region. Since no other facilities treat children exclusively, there should be no impact on existing providers. As stated elsewhere in this application, the physical plant at ETCH is seriously outdated. The hospital cannot operate as effectively or efficiently as it should without the renovations and expansion proposed by this project. In addition, the quality of the services offered could begin to suffer without these necessary renovation and expansion.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

   Response: The tables below show the current staffing pattern using FTEs for each unit and the average wages for these positions at East Tennessee Children's Hospital in comparison to the average wages in the region published by the Tennessee Department of Labor & Workforce Development.

EAST TENNESSEE CHILDREN'S HOSPITAL
CURRENT STAFFING PATTERNS
FTES

Unit	RN	LPN	Tech/CNA	HUC/Unit Secretary	Total
NICU	108	4	25	12	149
OR	22	1	22	2	47
PACU	12	0	2	1	15
OPS	14	0	5	2	21

EAST TENNESSEE CHILDREN'S HOSPITAL
AVERAGE WAGES AND
AVERAGE WAGES IN THE REGION

Position	Average for ETCH	Average in Region
Assistant Nurse Manager	$28.93	Not listed
Nurse	$23.86	$22.50
Personal Care Assistant	$11.18	$11.00 (Nursing Assistants)
ER Tech	$12.87	Not listed

Source: Tennessee Department of Labor & Workforce Development data on 2013 Tennessee Occupational Wages in Knoxville, MSA; East Tennessee Children's Hospital facility data.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: The applicant anticipates using current staff and does not anticipate having to hire new staff as there is not an expansion to the number of beds.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education*.

Response: As the facility is an existing hospital, the applicant understands and intends to comply with all licensing certification requirements for the State of Tennessee for medical/clinical staff.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.*, internships, residencies, etc.).

Response: The applicant participates in training programs for the following Schools of Nursing: University of Tennessee, South College, Carson Newman College, Lincoln Memorial University, Tennessee Technological University, Tennessee Wesleyan, Walters State Community College, Roane State Community College, and Pellissippi State. The application participates in resident rotations for the family practice program at ETSU's Quillen College of Medicine, medical student rotations at Lincoln Memorial University and the surgical residency program at UT.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response: As the applicant is an existing licensed hospital, it has reviewed and understands and currently follows the licensure requirements of the Department of Health and/or any applicable Medicare requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure:

Response: Department of Health, Board for Licensing Health Care Facilities.

Accreditation:

Response: Joint Commission; College of American Pathology (Lab)

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response: The applicant is currently in good standing with all licensing, certifying and accrediting agencies. Please see attached a copy of license from the State of Tennessee, included as Attachment C-Need-Contribution to the Orderly Development of Health Care, 7(c).

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response: All deficiencies have been corrected. A copy of the most recent inspection report and approved plan of correction are included as Attachment C-Need-Contribution to the Orderly Development of Health Care, 7(d).

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Response: Not applicable.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

Response: Not applicable.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Response: If approved, the applicant will provide the HSDA and/or the reviewing agency with information requested as appropriate.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response: Please see publication which occurred in the Knoxville News Sentinel on Friday, January 10, 2014.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Response: As the project will need to be staged in phases, the applicant is requesting additional time to complete the project and anticipates that it should be able to do so in approximately four years.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in TCA § 68-11-1609(c): April 23

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase		DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1.	Architectural and engineering contract signed	N/A	2/15/2014
2.	Construction documents approved by the Tennessee Department of Health	101	8/1/2014
3.	Construction contract signed	N/A	3/1/2014
4.	Building permit secured	101	8/1/2014
5.	Site preparation completed	196	11/6/2014
6.	Building construction commenced	197	11/7/2014
7.	Construction 40% complete	426	6/23/2015
8.	Construction 80% complete	728	4/21/2016
9.	Construction 100% complete (approved for occupancy) new building**	883	9/23/2016
10.	*Issuance of license	900	10/1/2016
11.	*Initiation of service	900	10/1/2016
12.	Final Architectural Certification of Payment	915	10/15/2016
13.	Final Project Report Form (HF0055)	930	11/1/2016

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

** **Renovation begins after occupancy of new building with the following schedule:**

14.	Phase II-Construction Commenced	884	9/24/2016
15.	Phase II-Construction 40% Complete	1,100	4/27/2017
16.	Phase II-Construction 80% Complete	1,424	3/13/2018
17.	Issuance of license/initiation of service	1,430	3/19/2018
18.	Final Project Report Form	1,445	4/3/2018

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AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

KIM H. LOONEY, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 15th day of January, 2014 a Notary Public in and for the County/State of Tennessee.

NOTARY PUBLIC

My commission expires January 6, 2015.

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.
My Commission Expires JAN. 6, 2015

Attachment B-1
Executive Summary

EXECUTIVE SUMMARY
EAST TENNESSEE CHILDREN'S HOSPITAL

1. **Services:** The applicant is East Tennessee Children's Hospital (ETCH), the only freestanding children's hospital serving the East Tennessee Perinatal Region. It was the first certified Comprehensive Regional Pediatric Center (CRPC) in Tennessee, which is the highest level of certification for pediatric care. It provides the full range of services for pediatric patients, including imaging, surgery, and Pediatric, NICU and Neonatal Abstinence Syndrome (NAS) inpatient beds. ETCH currently operates 152 beds, with 79 inpatient pediatric, 60 NICU and 13 ICU/CCU. No new beds are being added as a result of this project.

2. **Ownership Structure:** The applicant, East Tennessee Children's Hospital Association, Inc. is a non-profit entity. As such, there is no other entity in the ownership structure of the hospital.

3. **Project Cost:** The total project costs are approximately $75,300,000, including the project filing fees of $45,000.

4. **Renovation and Expansion:** The project includes 211,499 square feet of new space and 67,839 square feet of renovated space. It includes 10 operating rooms and 4 procedure rooms, 48 Pre-Post op bays to accommodate intake, pre- and post-operative care of both inpatients and outpatients in private settings, with options for opening up rooms between siblings, sterile processing to support surgery and procedure case preparations, and 60 private NICU rooms (including 16 private rooms for NAS). Construction is expected to take approximately 3 ½ years so the applicant is requested an extension to 4 years.

5. **Funding:** Funding for this project is expected to be provided by the issuance of bonds and from cash reserves of the hospital.

6. **Service Area:** The primary service area includes Anderson, Blount, Hamblen, Jefferson, Loudon, Roane, Sevier and Knox counties. ETCH also serves the remaining counties in the East Tennessee Perinatal Region, which includes the counties of Campbell, Claiborne, Cocke, Cumberland, Fentress, Grainger, Monroe, Morgan, Pickett, Scott, and Union.

7. **Staffing:** Since no new beds are being added and the new space is expected to be more efficient than the existing space, the applicant does not anticipate needing any additional staffing as a result of this project.

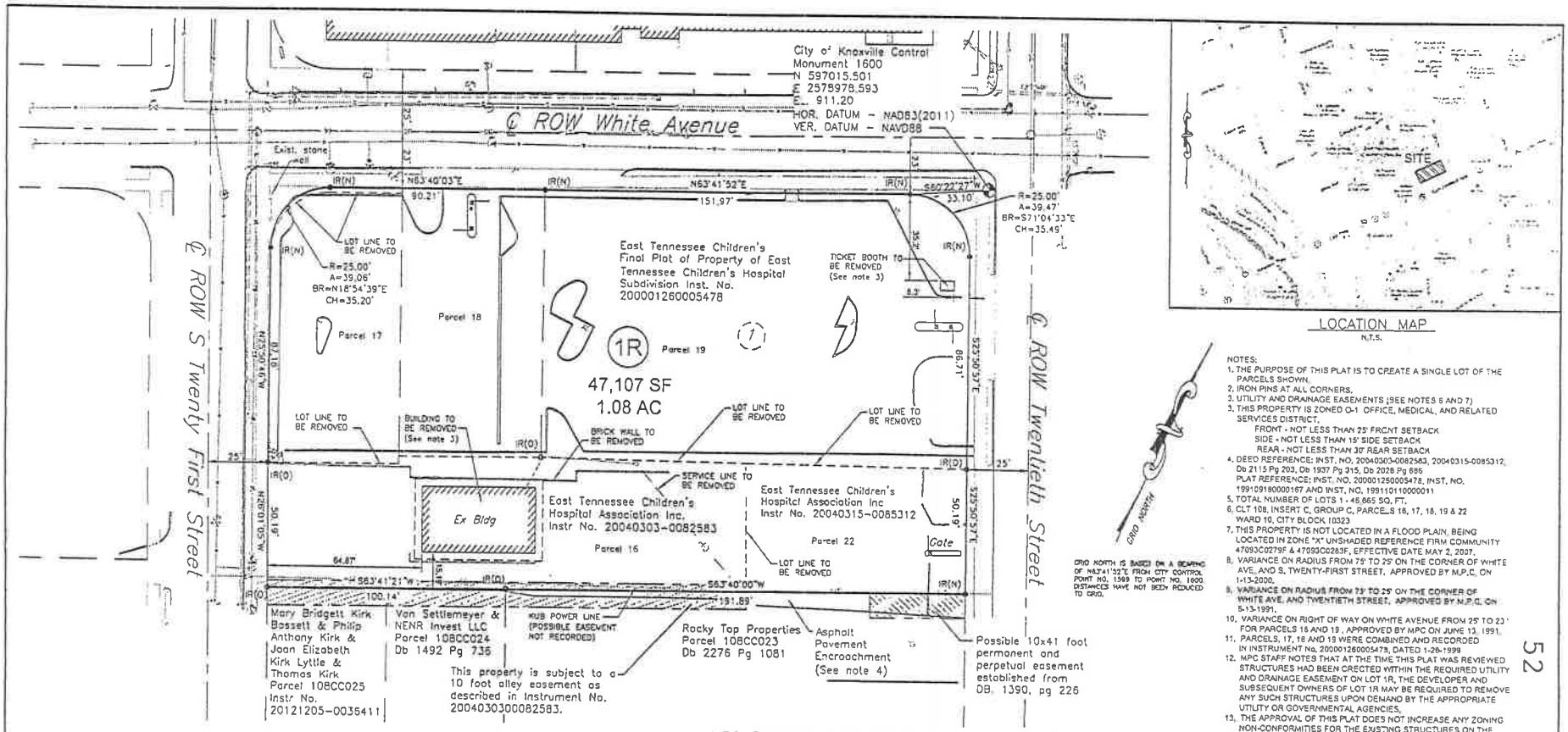
8. **Financial Feasibility:** The costs of the project are reasonable. The applicant expects to generate a positive net income in the first year of operation.

9. **Need:** Current ETCH facilities are at capacity. Over time, many family spaces in patient and public areas have been reduced or displaced to serve medical purposes. Portions of ETCH were built in the 1970's. Renovations occurred in the 1980's and again in the 1990's but these renovations are outdated as well. Children's hospitals have changed significantly since ETCH was built. The areas that are the primary focus of the renovation and expansion are the NICU, including the NAS unit, and the surgical areas.

Current standards are for NICU areas to be private rooms and to include space for the family in a more home-like environment. Operating rooms at ETCH are currently less than 400 square feet and the current standard is for operating rooms to have a minimum of 400 square feet. ETCH plans to build the new ORs with sufficient space for the most efficient operation. It is anticipated that 2 rooms will have 600 square feet, 8 will have 500 square feet, and the 4 procedure rooms will have 400 square feet. Without expansion, there is no space for ETCH to make these necessary changes.

10. **Contribution to the Orderly Development of Health Care:** ETCH is the only freestanding children's hospital in the East Tennessee Perinatal Region. It is also the only provider of inpatient pediatric beds in the service area. Only two other providers provide NICU beds in the service area - one at Level IIIB, which is the same as ETCH and one at Level IIB, which is not as high a level as the services provided at ETCH and UT. As such, there should be no impact on existing providers as a result of this project. The physical plant at ETCH is seriously outdated. The hospital cannot operate as effectively or as efficiently as it should and continue to provide the high quality of services that it has been providing without the renovation and expansion proposed by this project.

Attachment B.III(A)
Plot Plan



LOCATION MAP
N.T.S.

GRID NORTH IS BASED ON A BEARING OF N63°41'52"E FROM CITY CONTROL POINT NO. 1599 TO POINT NO. 1600. DISTANCES HAVE NOT BEEN REDUCED TO GRID.

NOTES:
1. THE PURPOSE OF THIS PLAT IS TO CREATE A SINGLE LOT OF THE PARCELS SHOWN.
2. IRON PINS AT ALL CORNERS.
3. UTILITY AND DRAINAGE EASEMENTS (SEE NOTES 6 AND 7)
3. THIS PROPERTY IS ZONED O-1 OFFICE, MEDICAL, AND RELATED SERVICES DISTRICT.
   FRONT - NOT LESS THAN 25' FRONT SETBACK
   SIDE - NOT LESS THAN 15' SIDE SETBACK
   REAR - NOT LESS THAN 30' REAR SETBACK
4. DEED REFERENCE: INST. NO. 20040303-0082583, 20040315-0085312, Db 2115 Pg 203, Db 1937 Pg 315, Db 2028 Pg 686
   PLAT REFERENCE: INST. NO. 200001260005478, INST. NO. 199109190000167 AND INST. NO. 199110110000011
5. TOTAL NUMBER OF LOTS 1 - 45,865 SQ. FT.
6. CLT 108, INSERT C, GROUP C, PARCEL S 18, 17, 18, 19 & 22
   WARD 10, CITY BLOCK 10323
7. THIS PROPERTY IS NOT LOCATED IN A FLOOD PLAIN, BEING LOCATED IN ZONE "X" UNSHADED REFERENCE FIRM COMMUNITY 47093C0279F & 47093C0283F, EFFECTIVE DATE MAY 2, 2007.
8. VARIANCE ON RADIUS FROM 75' TO 25' ON THE CORNER OF WHITE AVE. AND S. TWENTY-FIRST STREET, APPROVED BY M.P.C. ON 1-13-2000.
9. VARIANCE ON RADIUS FROM 75' TO 25' ON THE CORNER OF WHITE AVE. AND TWENTIETH STREET, APPROVED BY M.P.C. ON 5-13-1991.
10. VARIANCE ON RIGHT OF WAY ON WHITE AVENUE FROM 25' TO 23' FOR PARCELS 18 AND 19 , APPROVED BY MPC ON JUNE 13, 1991.
11. PARCELS, 17, 18 AND 19 WERE COMBINED AND RECORDED IN INSTRUMENT No. 200001260005479, DATED 1-26-1999
12. MPC STAFF NOTES THAT AT THE TIME THIS PLAT WAS REVIEWED STRUCTURES HAD BEEN CRECTED WITHIN THE REQUIRED UTILITY AND DRAINAGE EASEMENT ON LOT 1R, THE DEVELOPER AND SUBSEQUENT OWNERS OF LOT 1R MAY BE REQUIRED TO REMOVE ANY SUCH STRUCTURES UPON DEMAND BY THE APPROPRIATE UTILITY OR GOVERNMENTAL AGENCIES.
13. THE APPROVAL OF THIS PLAT DOES NOT INCREASE ANY ZONING NON-CONFORMITIES FOR THE EXISTING STRUCTURES ON THE PROPERTY NOR DOES IT CHANGE THE NONCONFORMING STATUS OF THE EXISTING STRUCTURES.DOCUMENTATION AS TO THE LEGAL STSTUS OF THE STRUCTURES OR VARIANCES FROM THE BOARD OF ZONING APPEALS MAY BE REQUIRED AT SOME LATER DATE FOR PERMIT APPLICATIONS OR OTHER DEVELOPMENT APPROVALS.
14. THIS PLAT INDICATES A PROPERTY ENCROACHMENT, IT HAS NOT BEEN ADDRESSED BY PLAT REVIEWING AGENCIES. OWNERS ARE RESPONSIBLE FOR RESOLVING PROPERTY BOUNDARY CONFLICTS.
15. VARIANCE FOR PARCEL 17 TO REDUCERIGHT OF WAY FROM 25' TO 23' ON WHITE AVENUE APPROVED BY MPC ON 9-12-13.
16. VARIANCE TO REDUCE THE STANDARD UTILITY AND DRAINAGE EASEMENT ON THE WEST, NORTH AND EAST EXTERIOR LOT LINE OF LOT 1R FROM 10' TO 0' APPROVED BY MPC ON 9-12-13.
17. VARIANCE TO REDUCE THE STANDARD UTILITY AND DRAINAGE EASEMENT FROM 10' TO 3' ON THE SOUTHERN EXTERIOR LOT LINE OF LOT 1R APPROVED BY MPC ON 9-12-13.

MPC FILE No. 9-SD-13-F

30 15 0 30 60
1"=30'

LEGEND

IR(O)	IRON ROD (OLD)
IR(N)	IRON ROD (NEW)
	PROPERTY LINE
	ADJOINING PROPERTY
	EXISTING STORM LINE
	CENTER LINE
①	LOT NO. (NEW)
(1)	LOT NO. (OLD)

Certificate of Ownership and General Declaration

I, We(_____) the undersigned owner of the property shown herein, hereby accept this as my plan of subdivision and dedicate the streets as shown to the public use forever and hereby certify that I am the owner in fee simple of the property, and as property owner have an unrestricted right to dedicate right of way and or grant easement as shown on this plat. I further certify that all restrictive covenants, if any, which apply to the lots are either shown on the plan or are referred to thereon, with copies of the referred to covenants filed with the Knox County register of deeds.

_____

_____

State of Tennessee, County of Knox

On this ____, Day of _____, 20___

Before me personally appeared _____

_____, to me known (or proved to me on the basis of satisfactory evidence) to be the person (or persons) described in and who executed the foregoing instrument, and acknowledged that he (or she or they) executed the same as his (or her or their) free act and deed.

_____
(Notary's Signature & Seal)

My Commission Expires:_____

Certification of Approval for Recording - Administrative Plat

This is to certify that the subdivision plat shown has been found to comply with the Subdivision Regulations of Knoxville and Knox County and with existing official plans, and the record plat is hereby approved for recording in the office of the Knox County Register of Deeds.

Signed: _____

Dated: _____

Right-of-Way Encroachment Certification

(I,We) _____ the undersigned owner(s) of the property shown herein, understand that the City of Knoxville is not approving the projection of any encroachment(s) into any right-of-way(s) as shown hereon, and that (I, We) accept full responsibility for any resulting consequences thereof.

Signed: _____

Dated: _____

City of Knoxville Engineering Division

The Knoxville Engineering Division hereby approves this plat on this the ___ Day of _____, 20___.

_____
Engineering Director

This is to certify that the subdivision shown hereon is approved subject to the installation of sanitary sewers and treatment facilities and that such installation shall be in accordance with state and local regulations.

Date _____ _____
Knox County Health Department

Zoning shown on official map_____

Date:_____ By:_____

I, the undersigned, hereby certify that the subdivision name and all street names conform to the Knoxville/Knox County Street Naming and Addressing Ordinance, the Administrative Rules of the Planning Commission, and these regulations.

Date:_____

By:_____

RELEASE OF EASEMENTS

Except as noted or shown on this plat, the following parties hereby consent to the release of all rights that may have accrued for their use and benefit in the utility and drainage easements along the original lot lines eliminated by this map, on the condition that new utility and drainage easements are provided along the new property lines.

City of Knoxville Engineering Department:
Signed:_____ Date:_____
Knoxville Utilities Board (Water & Wastewater)
Signed:_____ Date:_____
Knoxville Utilities Board (Gas):
Signed:_____ Date:_____
Knoxville Utilities Board (Electric):
Signed:_____ Date:_____
Bellsouth:
Signed:_____ Date:_____
Cable Television:
Signed:_____ Date:_____

Certification of Final Plat - Construction Complete

I hereby certify that I am a Surveyor licensed to practice surveying under the laws of the State of Tennessee. I further certify that this plan and accompanying drawings, documents and statements conform to all applicable provisions of the Knoxville/Knox County Subdivision Regulations except as has been itemized, described and justified in a report filed with the Metropolitan Planning Commission, or for variances for which application has been filed. The indicated monuments were in place on the ____ day of _____, 20___.

_____
Surveyor

Tennessee Certificate No._____

This is to certify that all property taxes and assessments due on this property have been paid.

Signed:_____ Date:_____
City Tax Clerk

Signed:_____ Date:_____
Knox County Trustee

EDDIE D. MILLER REGISTERED LAND SURVEYOR AGRICULTURE TENNESSEE NO. 2029

I HEREBY CERTIFY THAT THIS IS A CATEGORY 1 SURVEY AND THE RATIO OF THE PRECISION OF THE UNADJUSTED SURVEY IS 1:10,000 AS SHOWN HEREON.

OWNER
EAST TENNESSEE CHILDRENS HOSP
ADDRESS: 2018 CLINCH AVE
KNOXVILLE, TN 37916
PHONE: (865) 541-8000

FINAL PLAT OF LOT 1 OF THE PROP. OF EAST TENNESSEE CHILDREN'S HOSPITAL SUBDIVISION
DATE: 7-29-13
LDS PROJECT NO. 213075

LAND DEVELOPMENT SOLUTIONS

310 SIMMONS RD., SUITE K - KNOXVILLE, TENNESSEE 37922 - 865-671-2881

52

SUPPLEMENTAL #1
January 30 2014
3:00pm

SUPPLEMENTAL- # 1
January 30, 2014
3:00pm

Project
East Tennessee Children's Hospital
2018 Clinch Avenue
Barber McMurry Architects
Knoxville, Tennessee

LAND DEVELOPMENT SOLUTIONS
310 SIMMONS RD., SUITE K-KNOXVILLE, TENNESSEE 37922
PH. 865-671-2281

Drawing Description
Property Survey
53

No.	Revision	Date	By

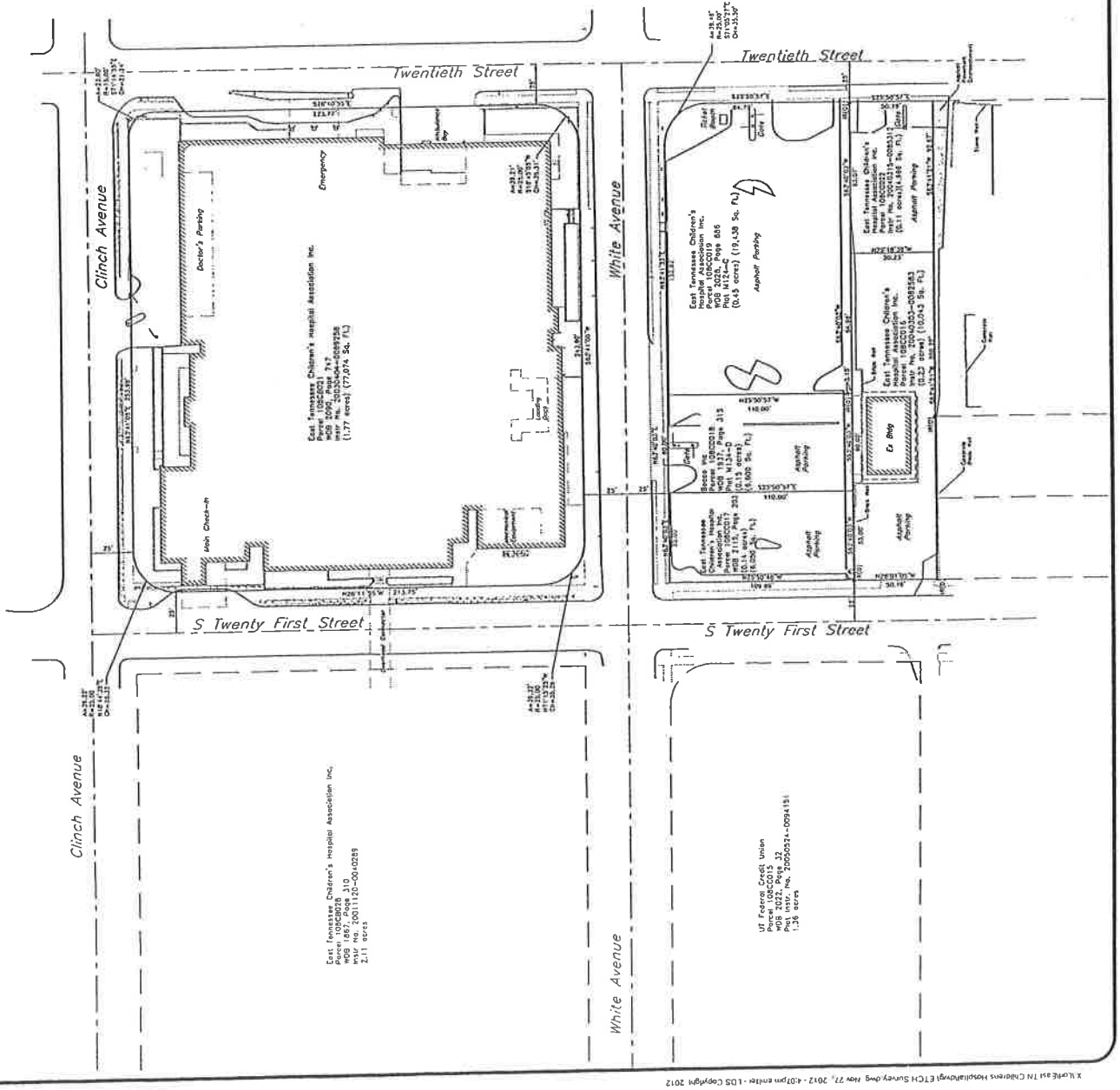
Drawn By | Checked | Approved | Job No. | Date | Scale | SHEET

Location Map (N.T.S.)

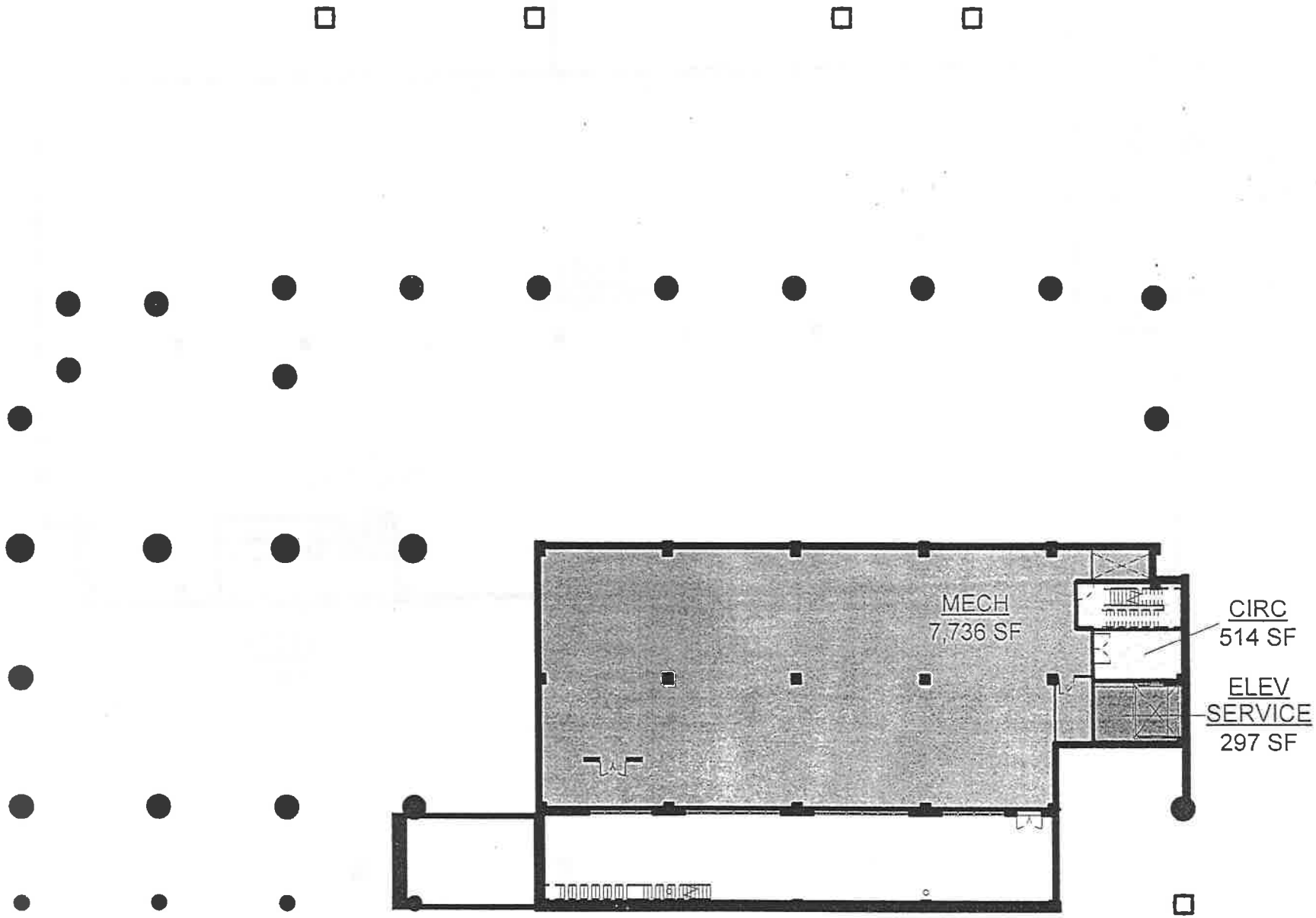
Legend

Iron Rod (Found)
Electrical Manhole
Power Pole
Light Pole
Sanitary Sewer Manhole
Sanitary Sewer
Fire Hydrant
Water Meter
Water Valve
Water Line
Gas Line
Fenceline
Property Line
Road Centerline
Adjacent Property Lines
Existing Building
Existing Contours
Existing Storm Sewer
Existing Storm Structures
Existing Curb
Existing Wall

GRID NORTH



Attachment B-IV
Floor Plan



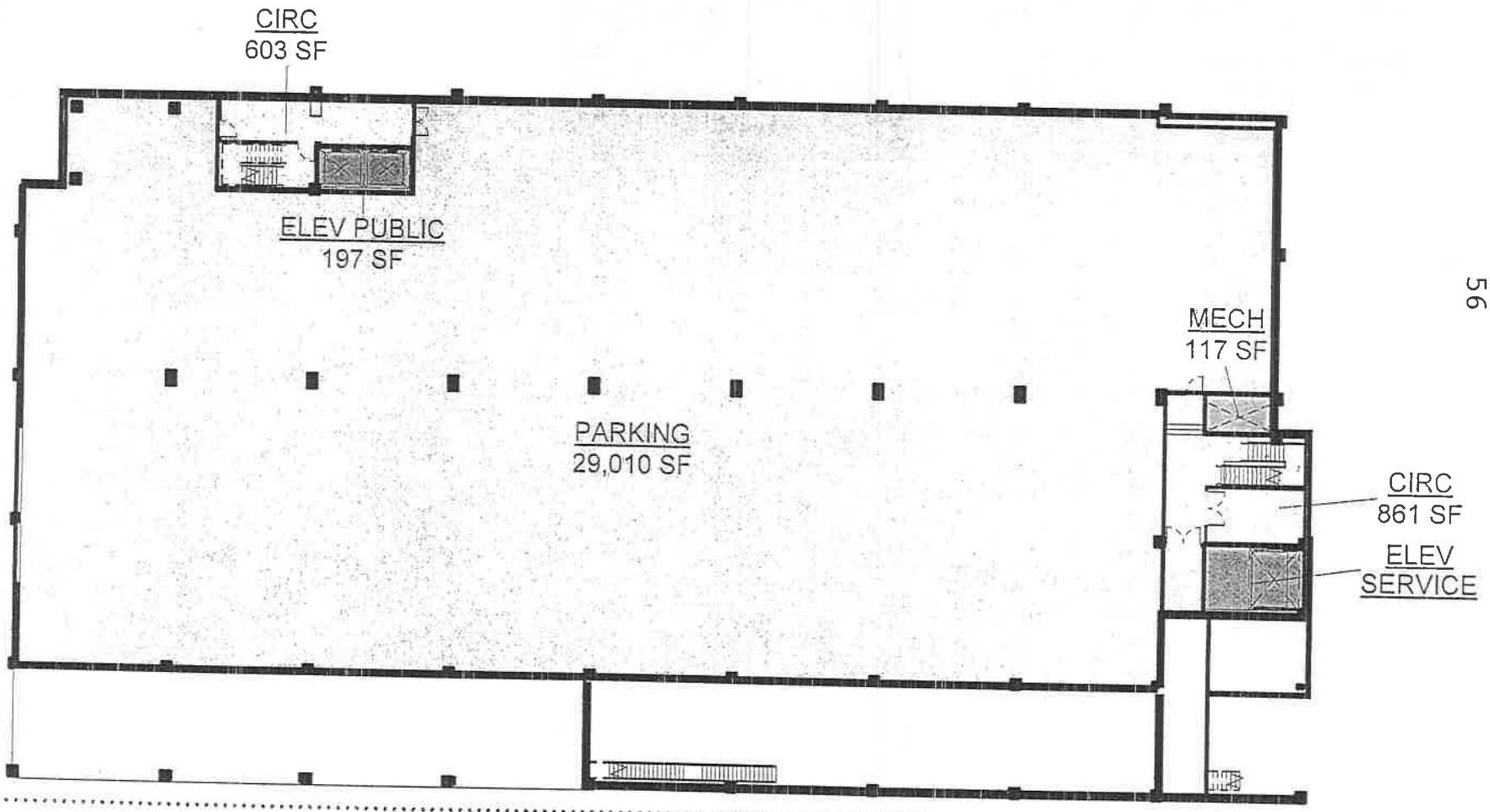
55

01.07.2014

CON - LEVEL SB AREA NEW CONSTRUCTION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

132500



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01.07.2014

CON - LEVEL P2 AREA NEW CONSTRUCTION

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EAST TENNESSEE CHILDREN'S HOSPITAL

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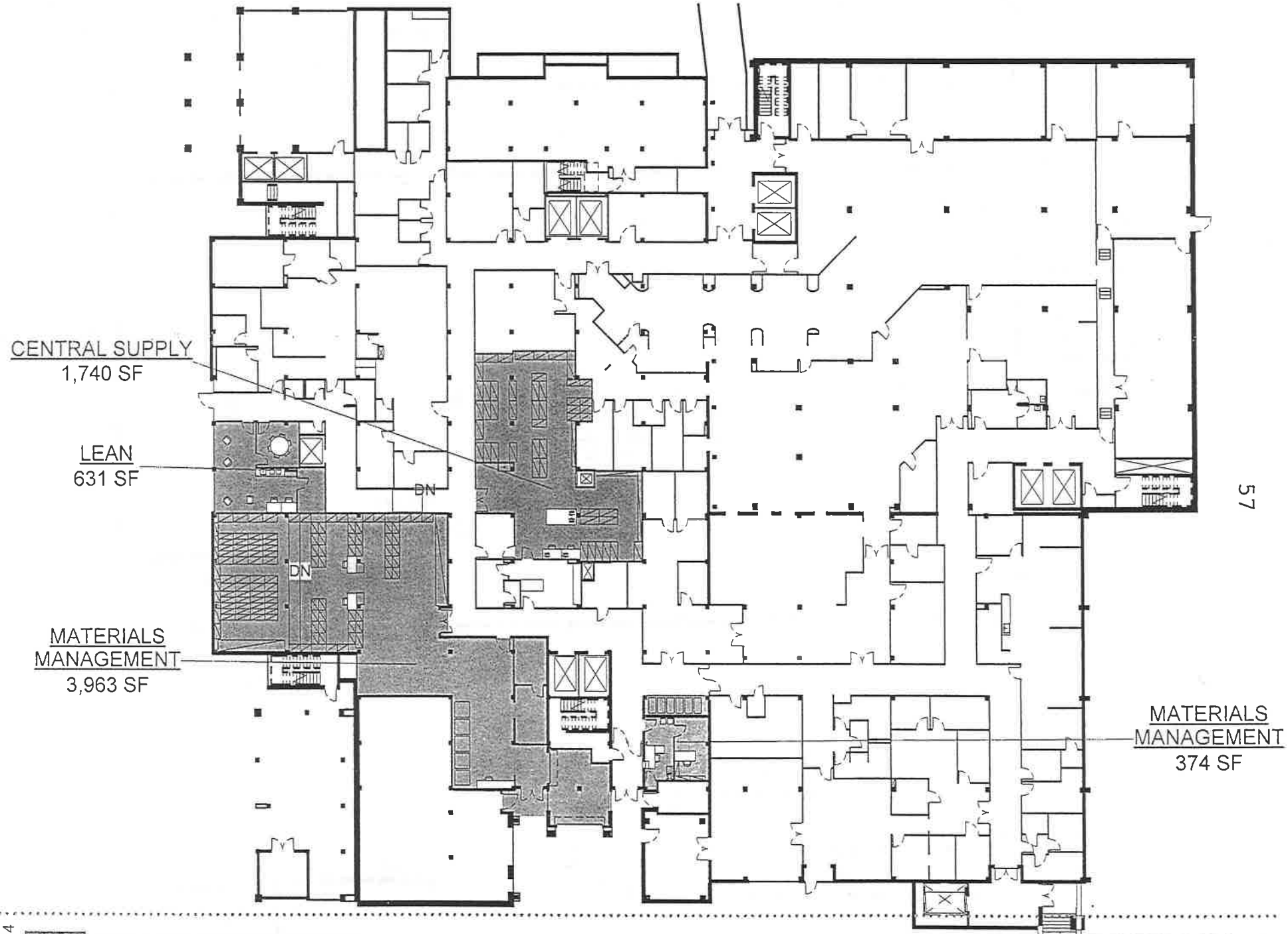

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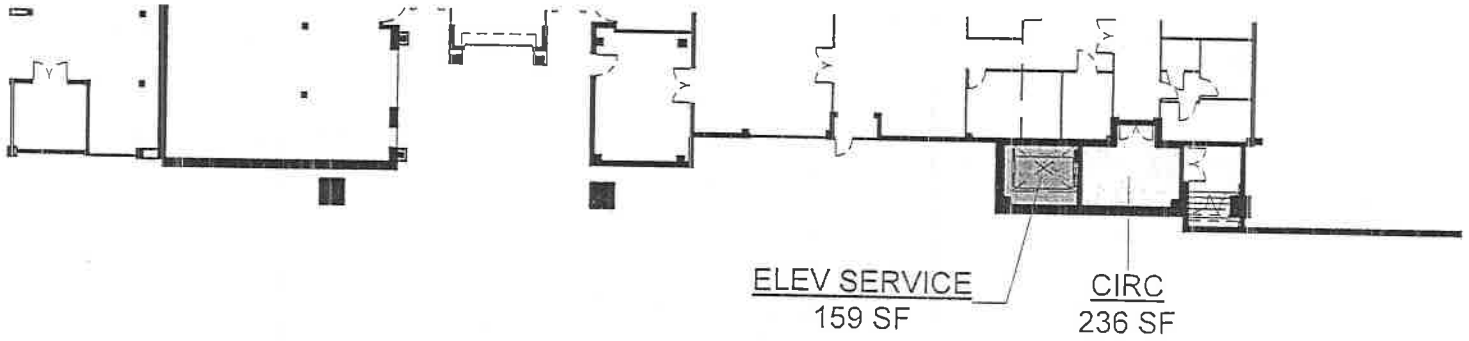
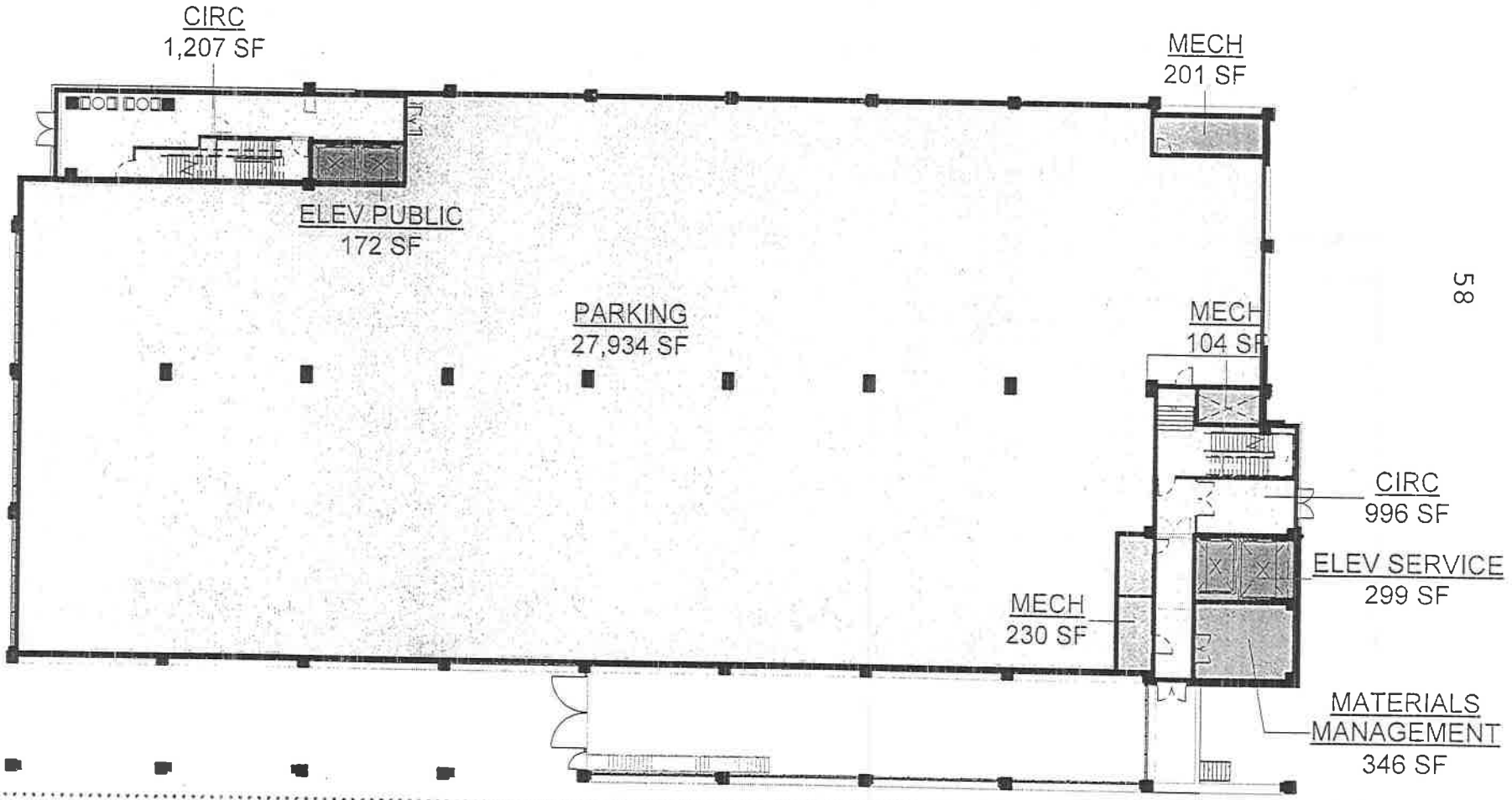
01.07.2014

CON - LEVEL 0 AREA RENOVATION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

134700





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01.07.2014

CON - LEVEL P1 AREA NEW CONSTRUCTION
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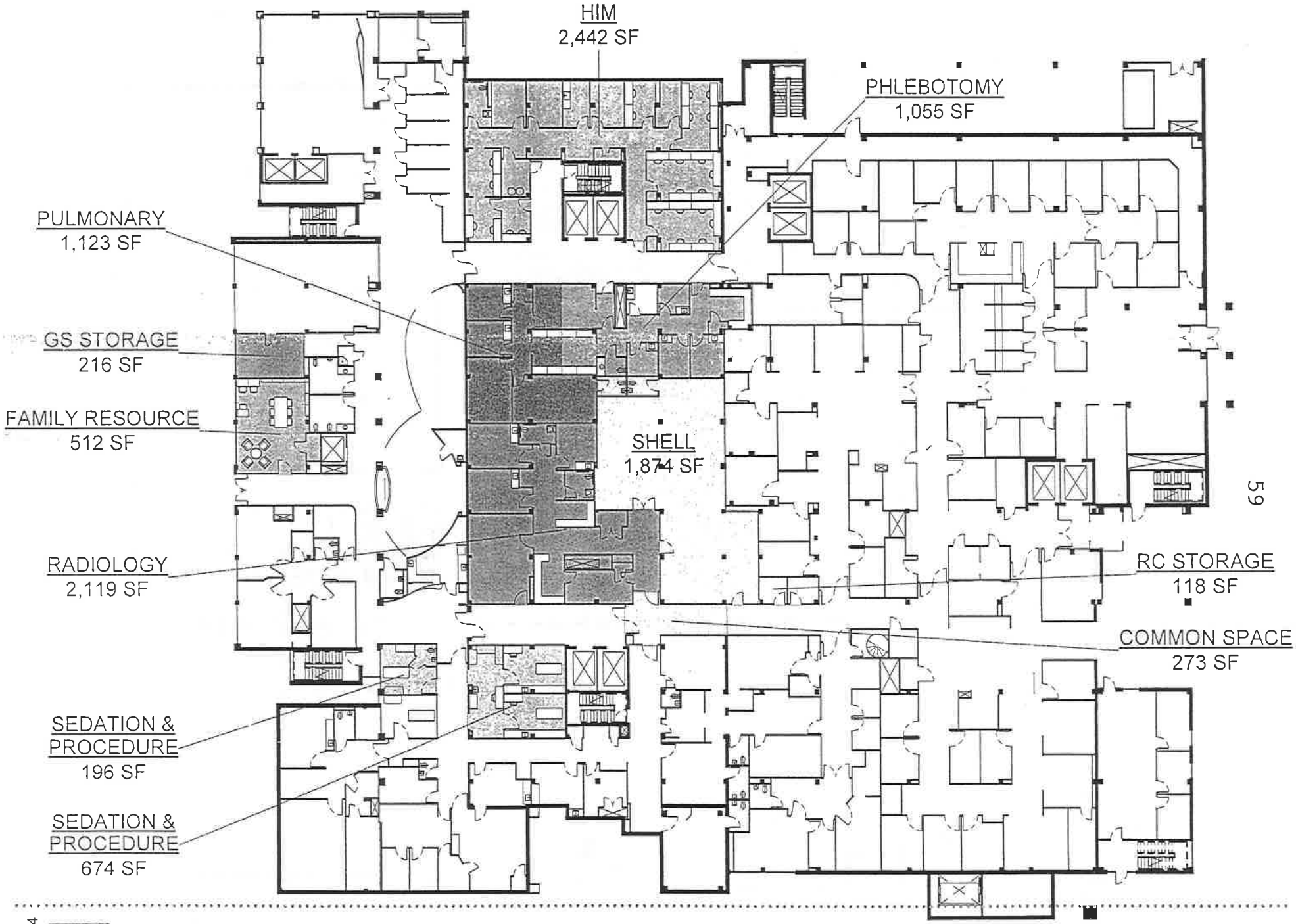

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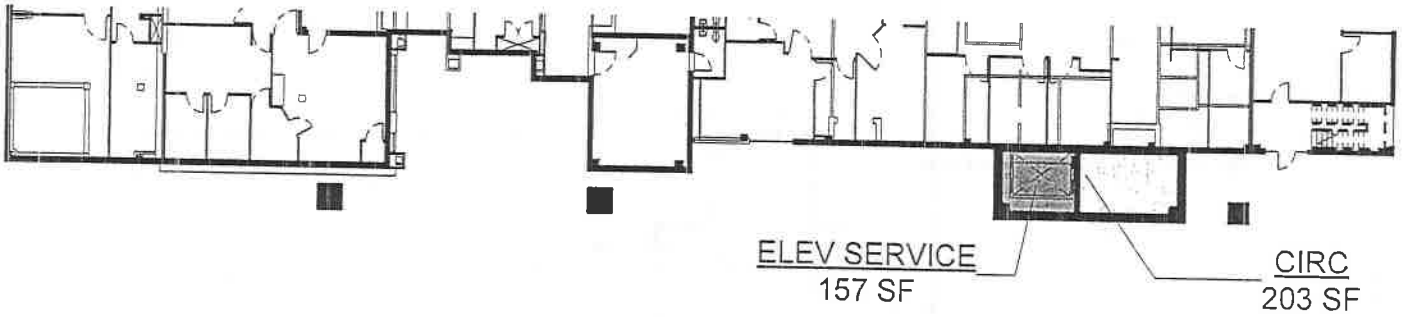
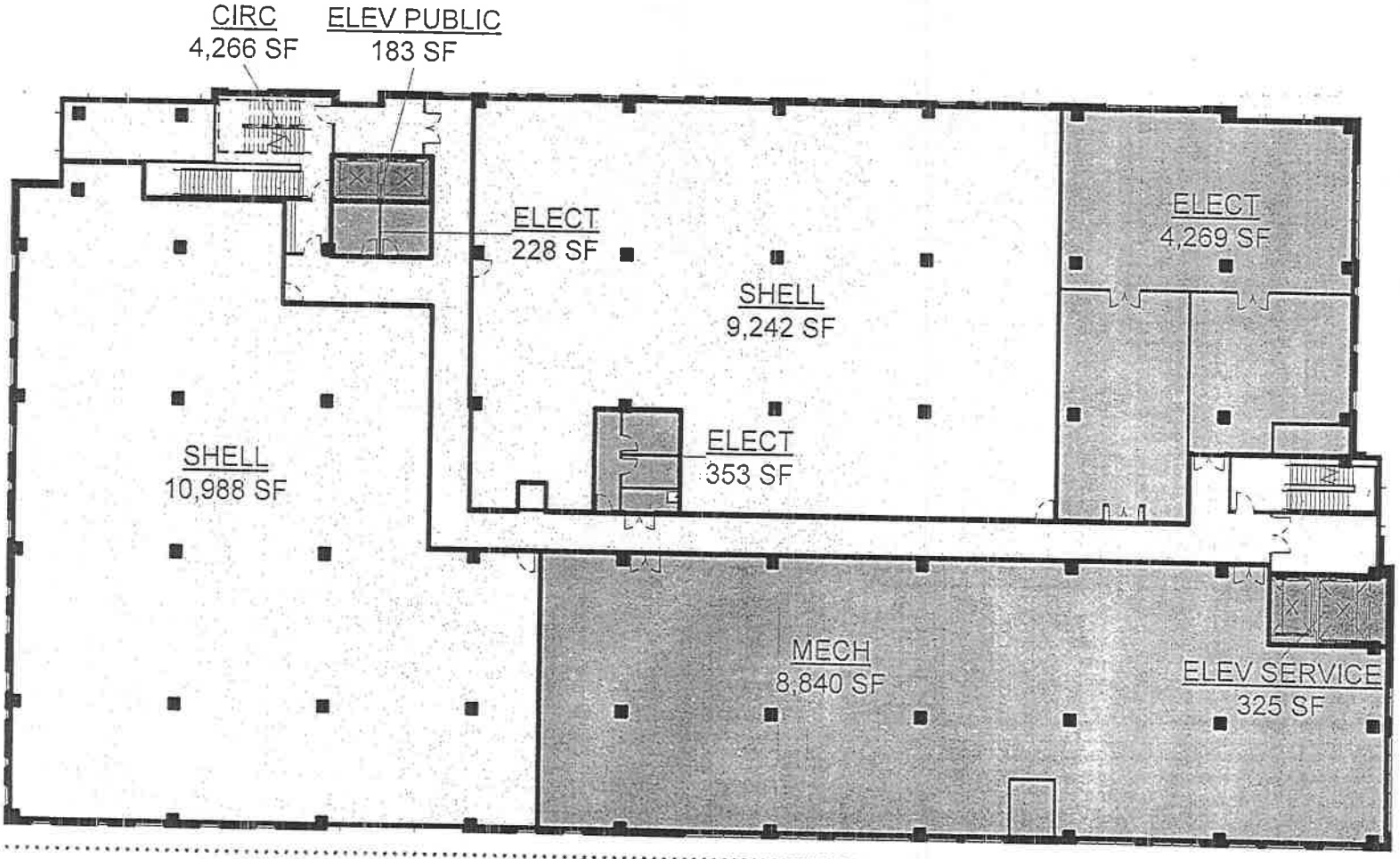
01.07.2014

CON - LEVEL 1 AREA RENOVATION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

134700





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01.07.2014

CON - LEVEL 1 AREA NEW CONSTRUCTION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

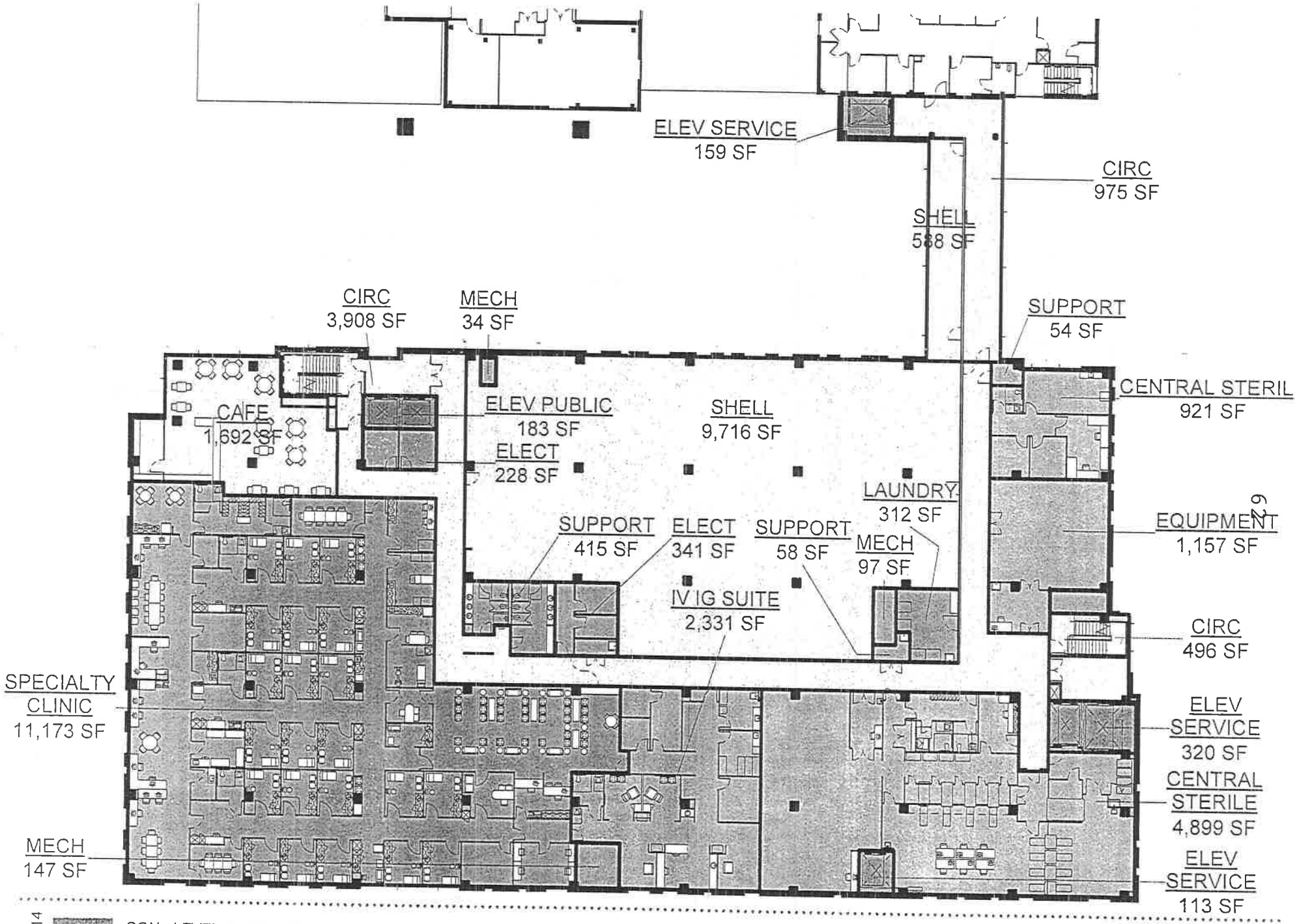
132500

01.07.2014

CON - LEVEL 2 AREA RENOVATION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

134700



01.07.2014

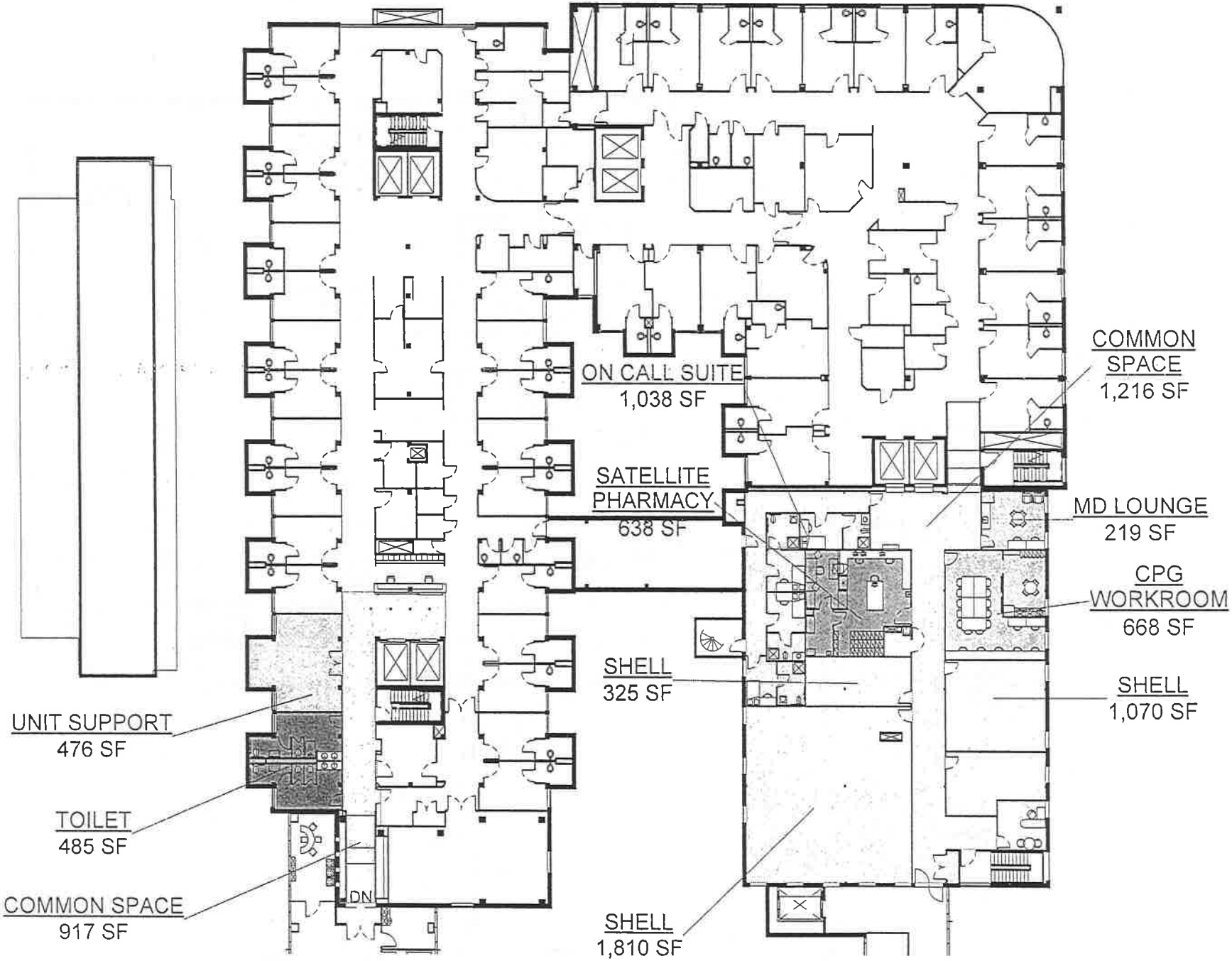
CON - LEVEL 2 AREA NEW CONSTRUCTION

ETCH SURGERY & NICU ADDITION

EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

132500

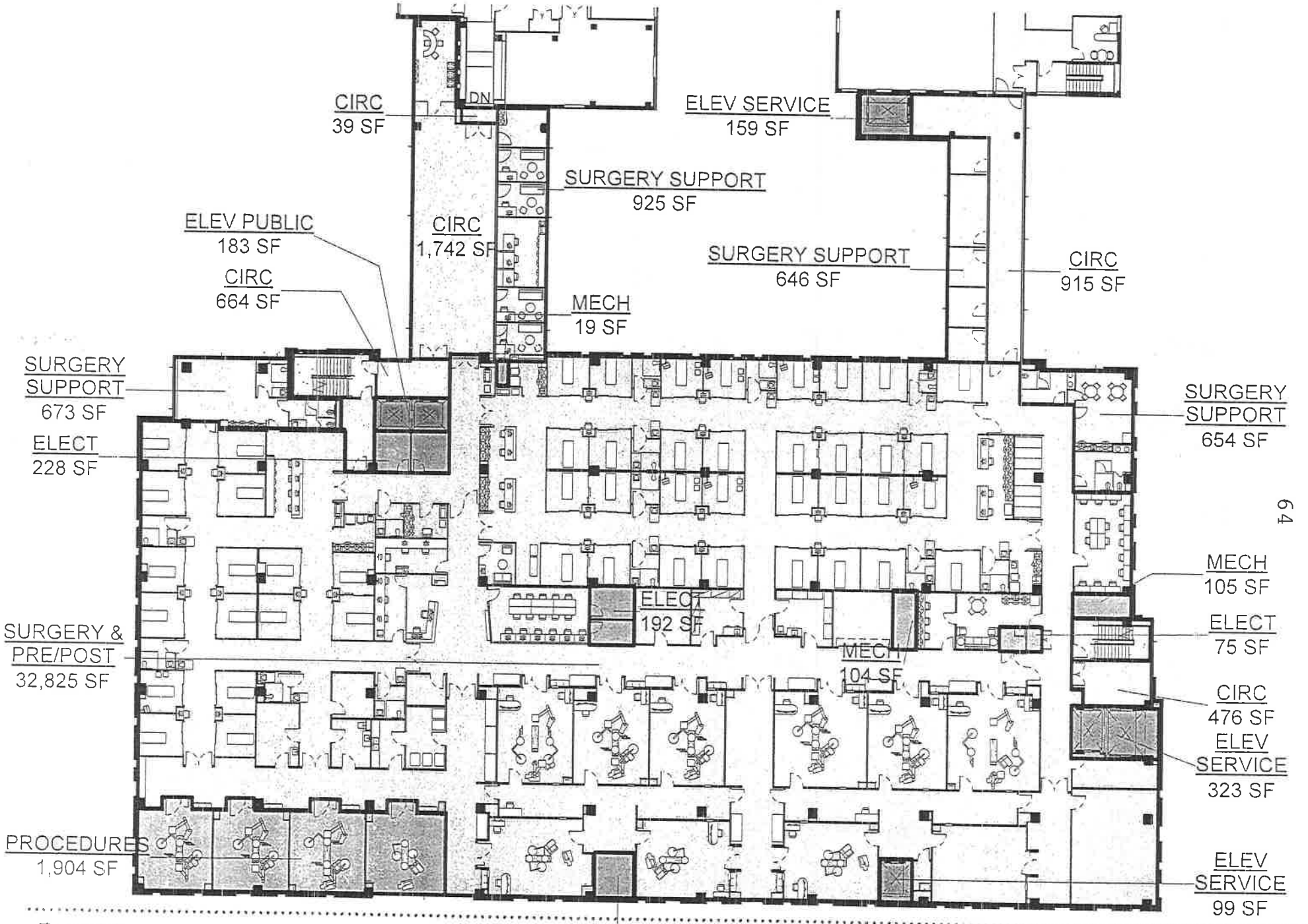


01.07.2014

CON - LEVEL 3 AREA RENOVATION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

134700



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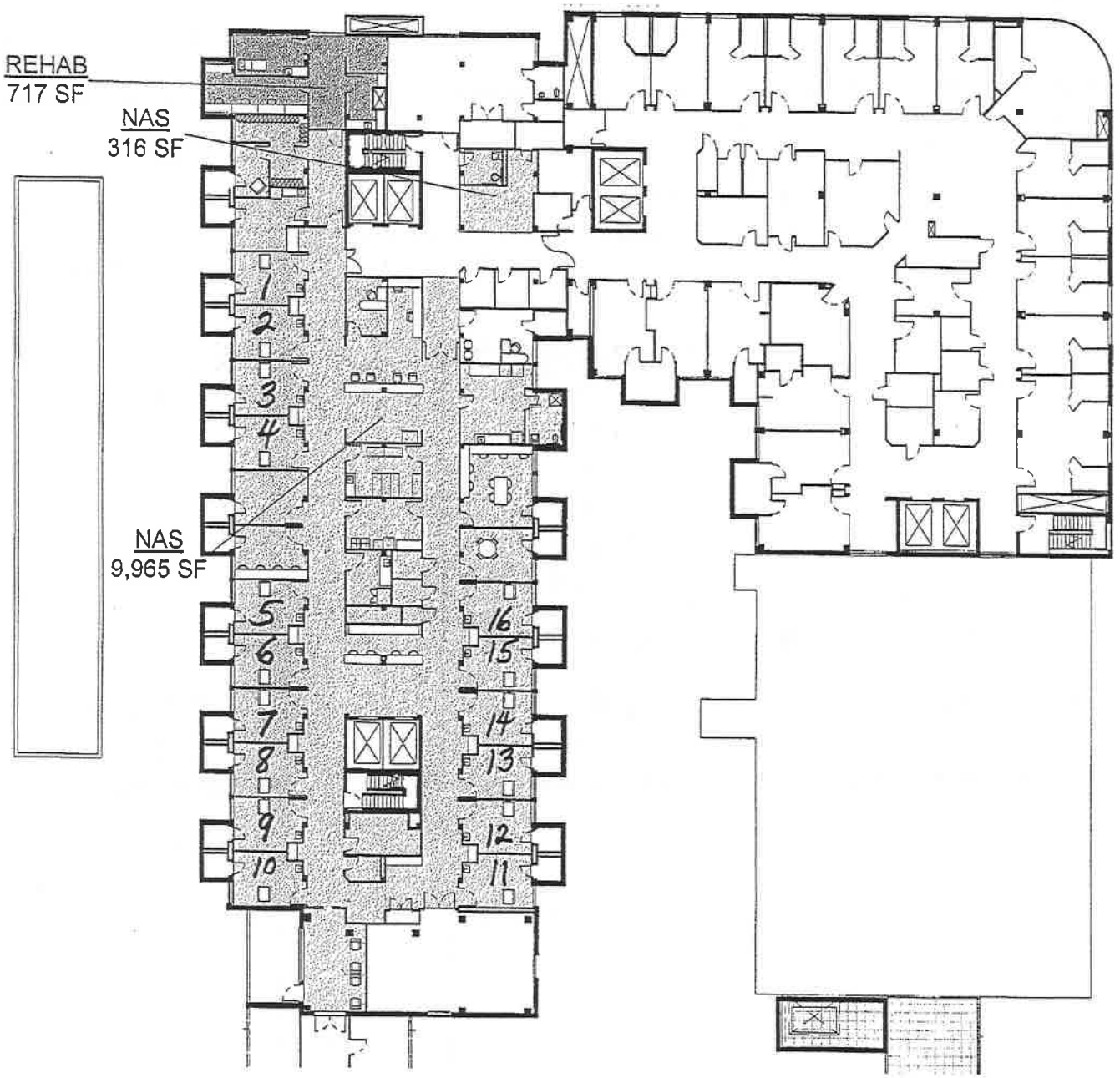
01.07.2014

CON - LEVEL 3 AREA NEW CONSTRUCTION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch dma BARBERMcMURRY architects since 1915

132500

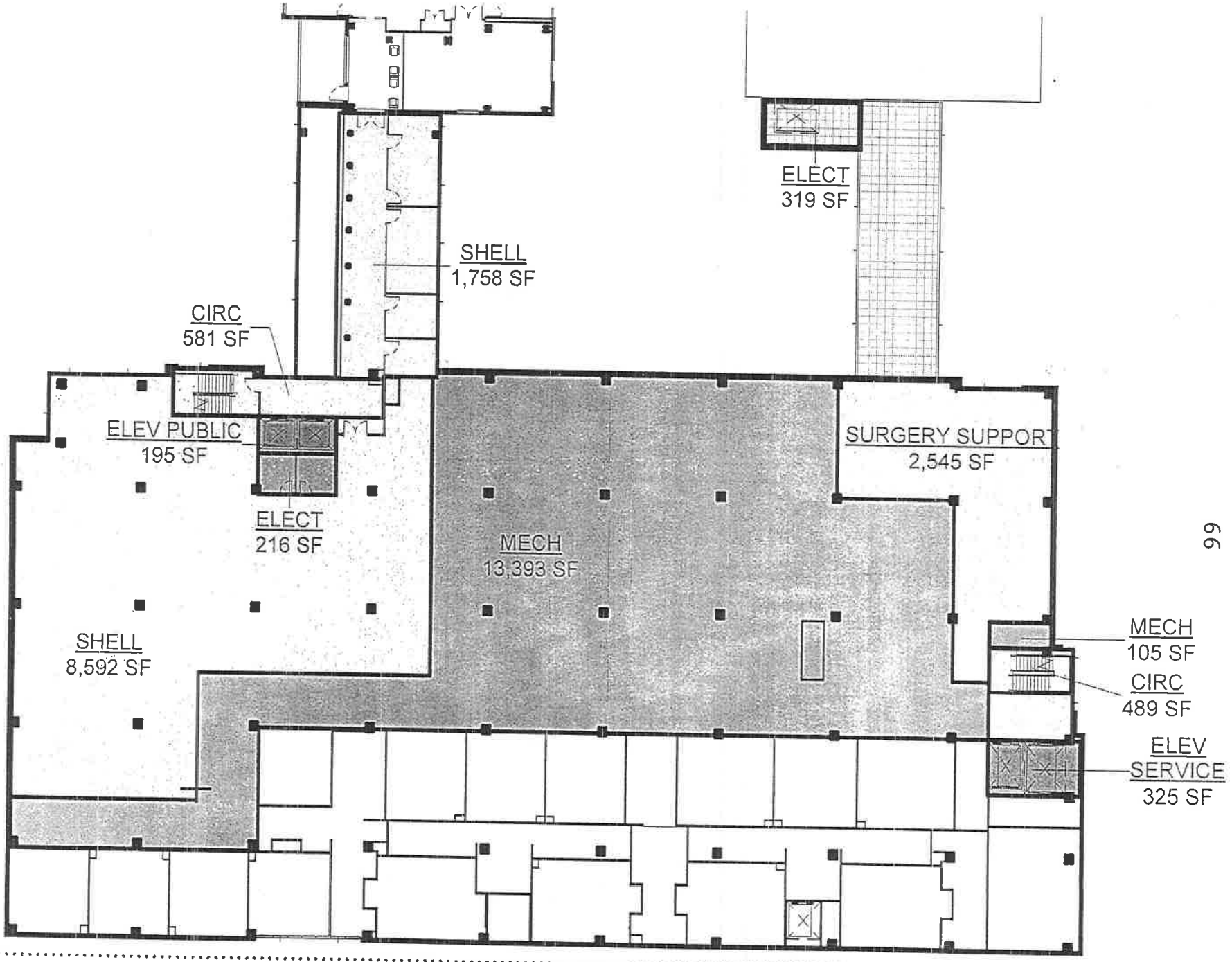


01 07 2014

CON - LEVEL 4 AREA RENOVATION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

134700



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01.07.2014

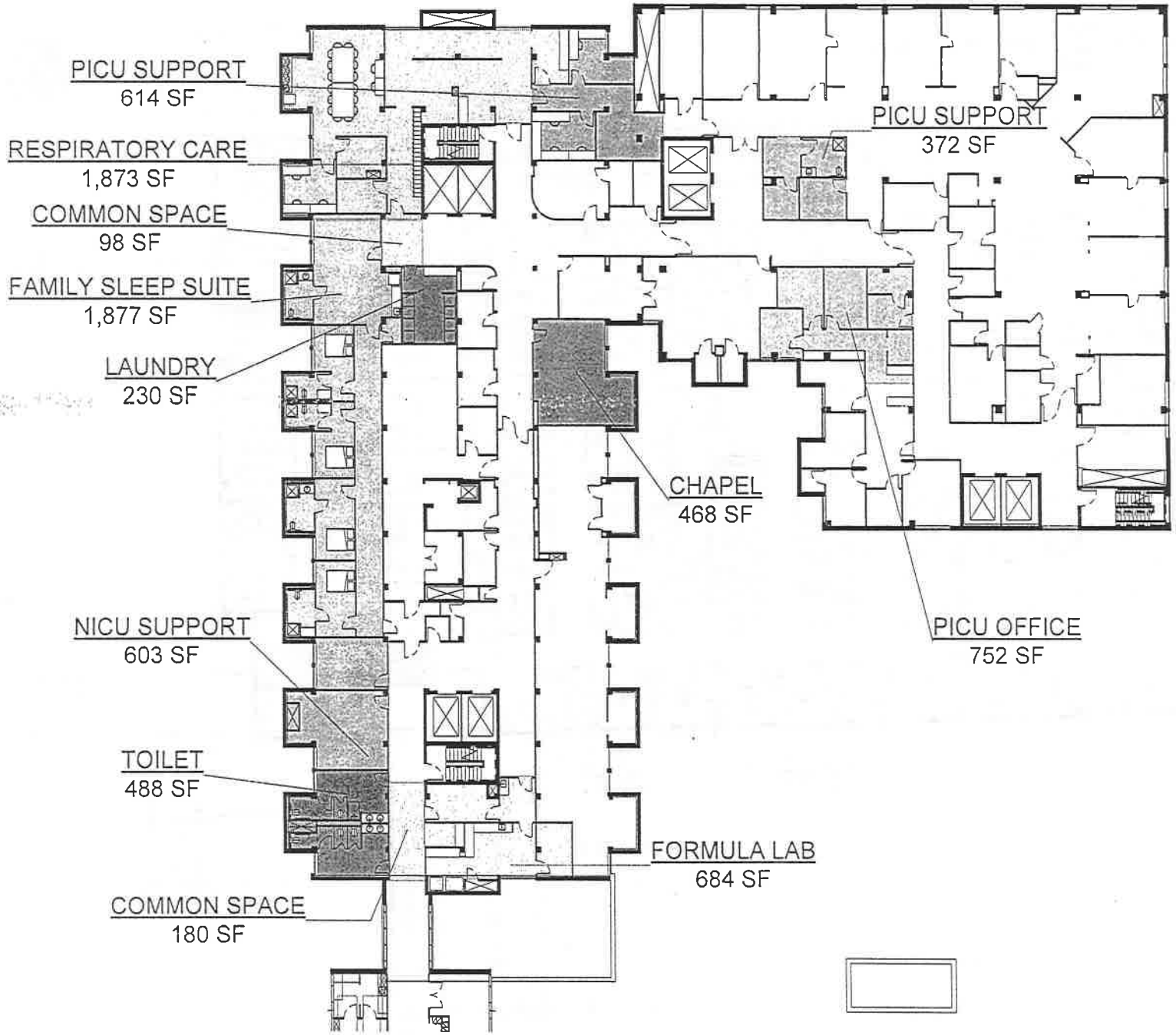
CON - LEVEL 4 AREA NEW CONSTRUCTION

ETCH SURGERY & NICU ADDITION

EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBERMcMURRY architects since 1915

132500



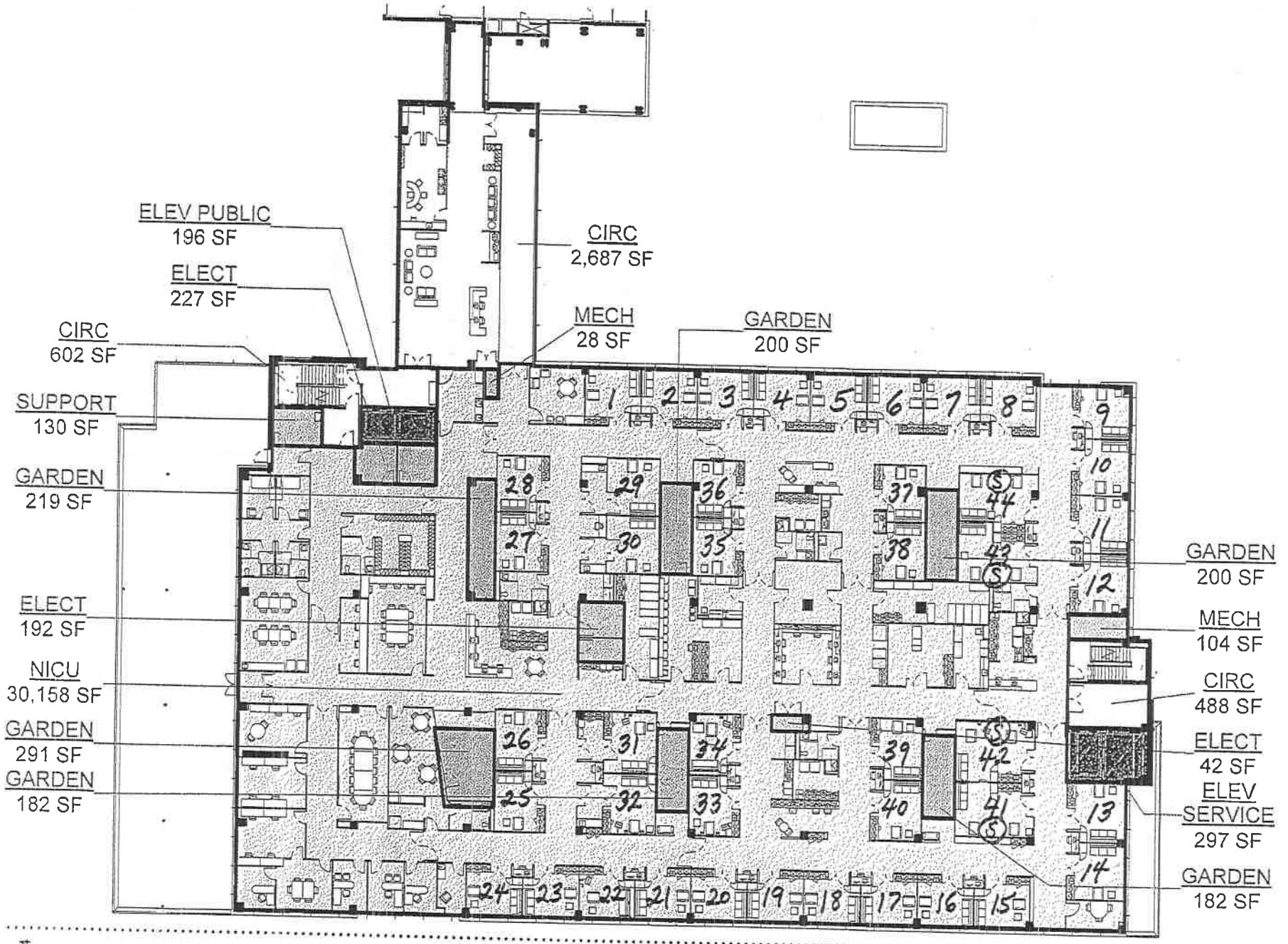
67

01.07.2014

CON - LEVEL 5 AREA RENOVATION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBER McMURRY architects since 1915

134700

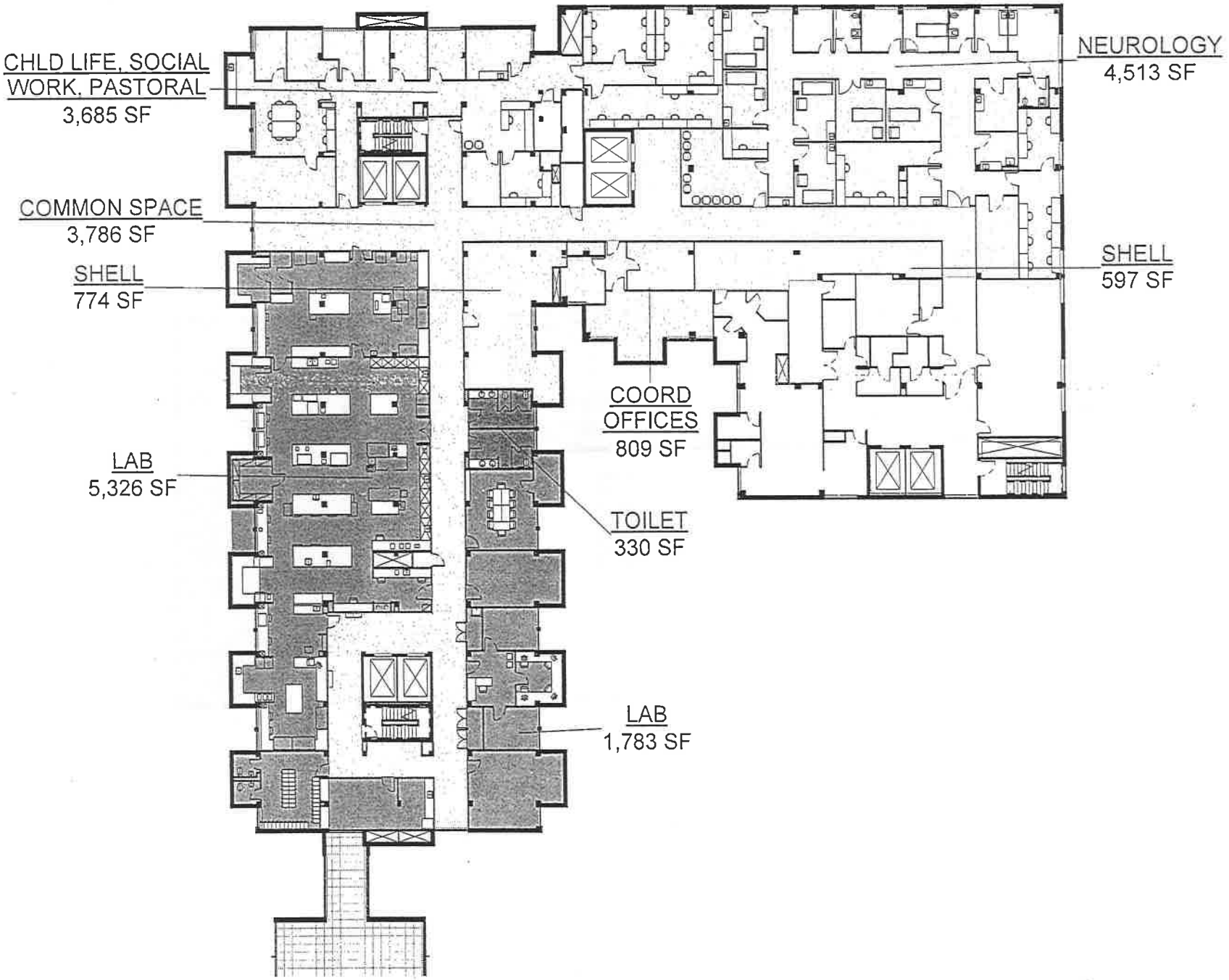


01 07 2014

CON - LEVEL 5 AREA NEW CONSTRUCTION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBER McMURRY architects since 1915

132500



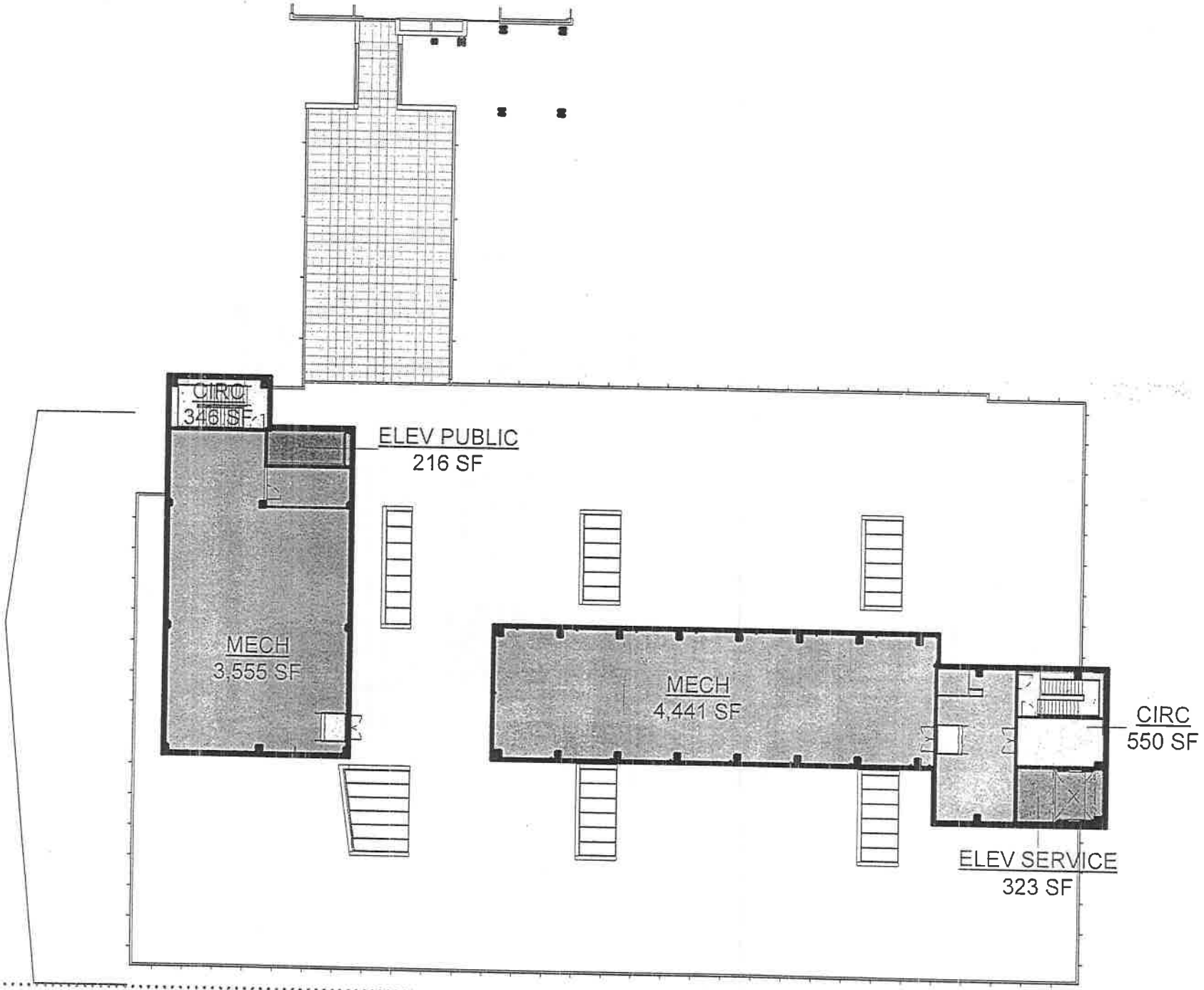
69

01.07.2014

CON - LEVEL 6 AREA RENOVATION
ETCH SURGERY & NICU ADDITION
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBER McMURRY architects since 1915

134700



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01.07.2014

CON - LEVEL 6 AREA NEW CONSTRUCTION

ETCH SURGERY & NICU ADDITION

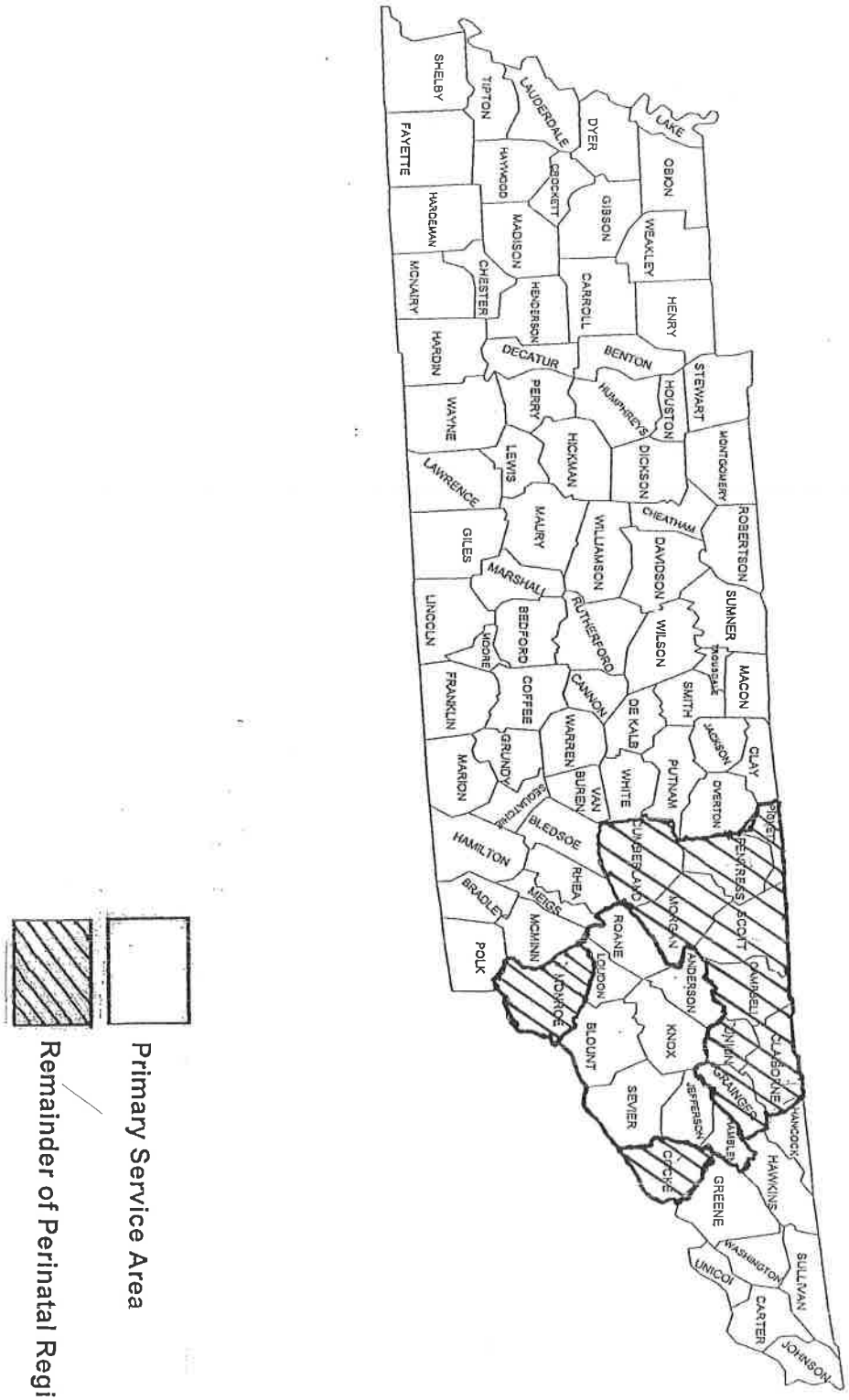
EAST TENNESSEE CHILDREN'S HOSPITAL

Shepley Bulfinch bma BARBER McMURRY architects since 1915

132500

Attachment C-Need-3
Service Area Map

STATE OF TENNESSEE



Primary Service Area

Remainder of Perinatal Region

Attachment C-Economic Feasibility-1
Contractor Letter

SUPPLEMENTAL- # 1
January 30, 2014
3:00pm

BARBERMcMURRY
architects since 1915

January 28, 2014

Mr. Rudy McKinley
Vice President for Operations
East Tennessee Children's Hospital
Clinch Ave
P O Box 15010
Knoxville, TN 37901-5010

RE: East Tennessee Children's Hospital
Surgery and NICU Addition & Renovations
Knox County, Tennessee
BMa Project No. 132500

Dear Mr. McKinley:

Thank you for selecting BarberMcMurry architects as your Architect-of-Record for the above referenced project. This firm has provided you, under separate cover, preliminary single-line floor plans showing the proposed improvements described in the program and narratives. This project is being designed to meet the requirements of the Guidelines for Design and Construction of Health Care Facilities, 2010 edition; and it will be designed to meet all applicable building codes, as listed below:

Project Scope:

Free-standing addition to East Tennessee Children's Hospital, located within block south of the existing building. Two above-grade bridge structures will connect this building to the existing hospital.

About 20% of the existing hospital will undergo significant renovation work.

The new building includes one sub-basement mechanical floor, two levels of parking, one level of mechanical interstitial space, and four levels of clinical and support space.

Applicable Codes - City of Knoxville:

International Building Code, 2012 Edition
International Energy Conservation Code, 2012 Edition
International Fuel Gas Code, 2012 Edition
International Mechanical Code, 2012 Edition
International Plumbing Code, 2012 Edition
International Fire Code, 2012 Edition
National Electrical Code (NFPA 70), 2008 Edition
ICC/ANSI A117.1 Accessibility Code, 2009 Edition
Knoxville Code of Ordinances: CH 6, ART 1, SEC 6-5, Fire District

Additional Codes—Tennessee Department of Health:

International Building Code, 2006 Edition
International Mechanical Code, 2006 Edition
International Plumbing Code, 2006 Edition
North Carolina Accessibility Code, 2004 Edition
FGI Guidelines For Construction Of Health Care Facilities, 2010 Edition
NFPA 101 Life Safety Code (LSC), 2006 Edition
NFPA 101 LSC (For CMS), 2000 Edition

Building Classifications:

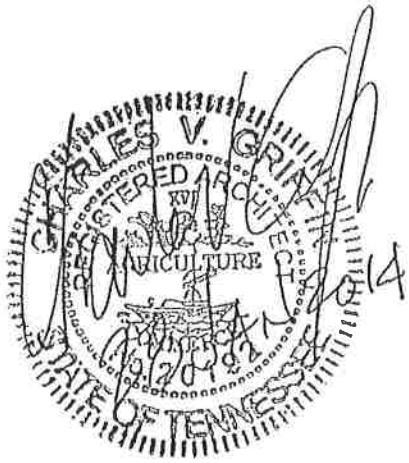
IBC Occupancy: Group I-2, Institutional
IBC Construction Type: Type 1B, Sprinklered
NFPA Occupancy (New Construction): New Health Care (LSC CH. 18)
NFPA Occupancy (Renovated Areas): Existing Health Care (LSC CH. 19)
NFPA Construction Type: Type I (3 3 2)

Fire Protection:

Interior Bearing Walls: Not Applicable
Columns: 2 or 3-hour protected
Beams: 2 or 3-hour protected
Floor/Ceiling Assembly: 2-hour rated
Roof/Ceiling Assembly: 1.5-hour rated
Exterior Bearing Walls: Not Applicable
Shaft Enclosures: 2-hour rated
Occupancy Separation: Not Applicable

Zoning:

Zoning Jurisdiction: City of Knoxville
Zoned: O-1 (Office, Medical, & Related Services)



Sincerely,

BarberMcMurry architects LLC

Charles V. Griffin, AIA
President
TN. License No. 020192

cc: File

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Attachment C, Economic Feasibility-2
Financing Letters

EAST TENNESSEE Children's Hospital

January 9, 2014

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, 9th Floor
Nashville, TN 37243

Per the June 30, 2013 audited financial statements, East Tennessee Children's Hospital Association had $150,535,070 in cash, cash equivalents, and trading securities and $41,543,825 in total long-term debt. No additional long-term debt has been added since June 30, 2013.

Sincerely,

Zane Goodrich
Vice President for Finance and
Chief Financial Officer

2018 Clinch Avenue
Knoxville, TN 37916
www.etch.com
p 865 541 8000

The Health, Educational and Housing Facility Board of the County of Knox
17 Market Square, #201
Knoxville, Tennessee 37902-1405
Phone: (865) 546-5887
Fax: (865) 546-6170

January 10, 2014

East Tennessee Children's Hospital Association, Inc.
2018 Clinch Avenue
Knoxville, Tennessee 37916
Attention: Zane Goodrich

Dear Zane:

We understand that East Tennessee Children's Hospital Association, Inc. (the "Hospital") is considering a tax-exempt bond transaction to finance certain facilities at the Hospital (the "Project"). In connection with your application for a certificate of need relating to the Project, you have requested that we provide you with a letter regarding our initial contact.

As you know, we have successfully completed multiple tax-exempt bond transactions with the Hospital in the past, including the transaction closed August 20, 2013. Based on our past experience with the Hospital and our understanding of the proposed Project, we would not expect any problems in serving as the conduit issuer for the proposed financing.

Please consider this letter as evidence that the Hospital and The Health, Educational and Housing Facility Board of the County of Knox have had favorable initial contact with respect to the proposed financing of the Project through a conduit bond issue.

THE HEALTH, EDUCATIONAL AND HOUSING FACILITY BOARD OF THE COUNTY OF KNOX

By: _____
Chair

12712428.1

PONDER & CO

105 St. Dunstans Road
Baltimore, MD 21212 410-435-6745 Phone and Fax

PROPOSED DRAFT

January 10, 2014

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: **Financing East Tennessee Children's Hospital's New Construction and Renovation**

Dear Ms. Hill:

The purpose of this letter is to provide Ponder & Co.'s opinion that the debt financing plan required for East Tennessee Children's Hospital's ("ETCH") proposed construction and renovation project is feasible. For the past year, Ponder & Co. has provided independent financial advice to ETCH in its capacity as financial advisor to healthcare organizations on matters of capital formation and capital markets transactions.

Ponder & Co. bases its opinion on the firm's extensive experience with capital financing and debt offerings for non-profit hospital organizations, like ETCH. Since 1985, Ponder & Co. has served as independent, financial advisor to non-profit hospital organizations for over 1,500 public debt offerings (totaling approximately $87 billion) for major capital projects, including replacement hospitals. The firm's professionals have also prepared over 500 capital access plans and debt capacity studies for hospital organization clients, like ETCH, during the same period.

The Board and Management of ETCH have determined that the new construction and renovation at its main campus in Knoxville, Tennessee (the "Project") is best for the community it serves and ETCH's future operation. We believe that the Project is financially feasible based upon our review of the facts and the reasonable assumptions provided by ETCH management regarding (1) the Project's estimated total cost, (2) ETCH's strong operating results, modest debt burden, and significant cash reserves, (4) the Project's expected patient demand and operating efficiencies and (5) ETCH's projected financial performance.

Ponder & Co. has also considered the proposed amount of debt financing for the Project. We believe that ETCH will be able to sell tax-exempt securities at acceptable interest rates to fund the portion of the Project that is not funded with ETCH's cash reserves and community donations. We anticipate that ETCH will receive investment grade bond ratings of "Baa1" from Moody's Investors Service and "BBB+" from Standard & Poor's Corporation, the two rating agencies which have rated ETCH's bonds in the past and evaluated its overall creditworthiness. We also expect significant interest from a number of bank lenders and bond underwriters to purchase the proposed bonds for the Project.

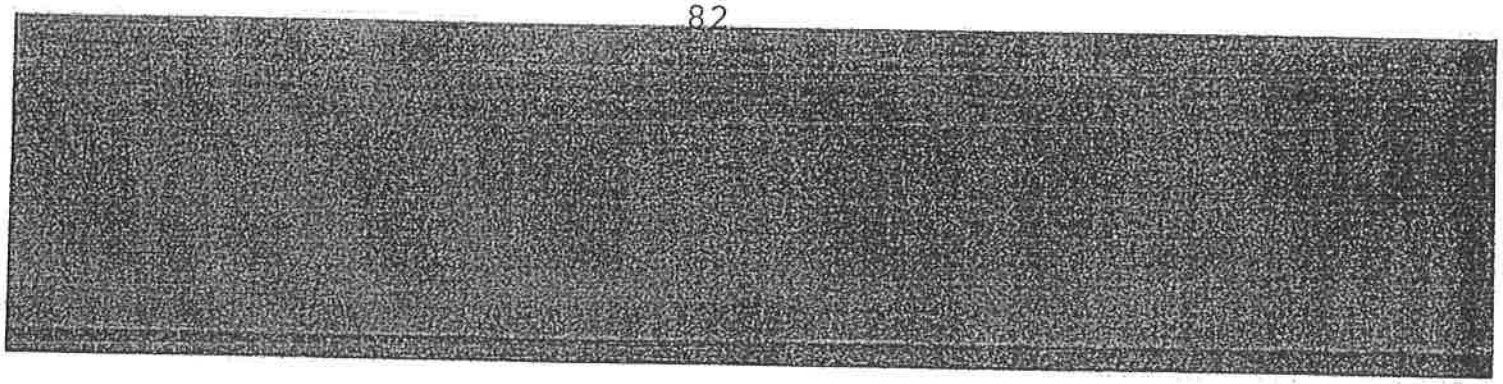
We hope that the information provided in this letter will be helpful to the Health Services and Development Agency during its review of ETCH's Certificate of Need application. Do not hesitate to contact me directly, if you have questions or if there is any additional information which we can provide.

Sincerely yours,

John E. Cheney

John E. Cheney
Senior Vice President
(410) 435-6745 or jcheney@ponderco.com

Attachment C, Economic Feasibility-10
Audited Financials



EAST TENNESSEE CHILDREN'S HOSPITAL ASSOCIATION, INC. AND SUBSIDAIRIES

Audited Consolidated Financial Statements

Years Ended June 30, 2013 and 2012

PYA

Certified Public Accountants

EAST TENNESSEE CHILDREN'S HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

Audited Consolidated Financial Statements

Years Ended June 30, 2013 and 2012

PYA
Certified Public Accountants

PERSHING YOAKLEY & ASSOCIATES, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of East Tennessee
Children's Hospital Association, Inc.:

We have audited the accompanying consolidated financial statements of East Tennessee Children's Hospital Association, Inc. and subsidiaries (the Hospital), which comprise the consolidated balance sheets as of June 30, 2013 and 2012, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatements, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Hospital's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of East Tennessee Children's Hospital Association, Inc. and subsidiaries as of June 30, 2013 and 2012, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
September 18, 2013

EAST TENNESSEE CHILDREN'S HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

	June 30, 2013	June 30, 2012
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 32,461,421	$ 32,228,925
Assets limited as to use	2,238,120	2,204,600
Patient accounts receivable, less estimated allowances for uncollectible accounts and contractual adjustments of $28,749,000 in 2013 and $31,634,000 in 2012	28,476,238	31,411,628
Other receivables, net	299,973	261,376
Inventories and prepaid expenses	3,770,159	3,464,373
TOTAL CURRENT ASSETS	67,245,911	69,570,902
ASSETS LIMITED AS TO USE, under bond indenture agreements - held by trustee, less current portion	3,304,144	3,362,061
TRADING SECURITIES	118,073,649	74,625,545
PROPERTY, PLANT AND EQUIPMENT, net of accumulated depreciation	76,260,226	76,748,774
OTHER ASSETS		
Cash, investments and other assets restricted by donors for long-term purposes	20,702,731	20,040,118
Notes receivable and other	1,455,642	1,594,247
Land held for expansion	436,201	421,201
Deferred financing costs, net	1,108,272	1,161,469
Intangible asset	248,432	383,000
Investment in joint venture	1,058,506	962,235
TOTAL OTHER ASSETS	25,009,784	24,562,270
TOTAL ASSETS	$ 289,893,714	$ 248,869,552

	June 30, 2013	2012
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Current portion of long-term debt	$ 1,150,000	$ 1,100,000
Accounts payable and accrued expenses	11,060,360	11,178,658
Accrued compensation, benefits and payroll taxes	10,368,247	9,382,357
Estimated payable to third-party payers, net	2,401,306	733,108
CURRENT LIABILITIES	24,979,913	22,394,123
OTHER LIABILITIES		
Other long-term and estimated professional liabilities	300,000	410,000
Long-term debt, net of current portion	40,393,825	41,531,527
TOTAL LIABILITIES	65,673,738	64,335,650
COMMITMENTS AND CONTINGENCIES - Note K		
NET ASSETS		
Unrestricted	198,949,366	161,397,098
Temporarily restricted	9,104,210	7,103,337
Permanently restricted	16,166,400	16,033,467
TOTAL NET ASSETS	224,219,976	184,533,902
TOTAL LIABILITIES AND NET ASSETS	$ 289,893,714	$ 248,869,552

See notes to consolidated financial statements.

EAST TENNESSEE CHILDREN'S HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets

	Year Ended June 30,	
	2013	*2012*
CHANGES IN UNRESTRICTED NET ASSETS:		
Unrestricted revenue, gains, and support:		
Patient service revenue, net of contractual allowances	$ 210,565,784	$ 203,541,686
Provision for bad debts	(3,691,343)	(4,110,085)
Net patient service revenue	206,874,441	199,431,601
Other revenue:		
Other operating revenue, net	5,850,203	3,600,050
Unrestricted donations	1,416,497	305,940
Net assets released from restrictions used for operations	2,151,680	1,987,005
TOTAL REVENUE, GAINS AND SUPPORT	216,292,821	205,324,596
EXPENSES:		
Salaries and wages	87,012,523	81,913,854
Employee benefits	23,973,058	23,268,185
Supplies	30,679,477	28,602,160
Professional fees and services	22,100,684	22,088,874
Depreciation and amortization	7,970,424	7,332,047
Interest	2,181,202	2,254,635
Other	15,354,890	14,203,923
TOTAL EXPENSES	189,272,258	179,663,678
OPERATING INCOME	27,020,563	25,660,918
Other gains:		
Net investment gain	6,181,866	1,819,655
Net gain on disposal of assets	9,580	586,041
Equity in earnings of joint venture	1,030,899	799,110
Other nonoperating gains	38,877	-
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	34,281,785	28,865,724
Net assets released from restrictions used for the purchase of property, plant and equipment or principal payments on long-term debt	3,270,483	822,467
INCREASE IN UNRESTRICTED NET ASSETS	37,552,268	29,688,191
Unrestricted net assets, beginning of year	161,397,098	131,708,907
Unrestricted net assets, end of year	$ 198,949,366	$ 161,397,098

	Year Ended June 30, 2013	2012
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS:		
Temporarily restricted contributions	$ 5,063,441	$ 4,135,848
Net investment income	2,359,595	807,331
Net assets released from restrictions	(5,422,163)	(2,809,472)
INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	2,000,873	2,133,707
Temporarily restricted net assets, beginning of year	7,103,337	4,969,630
Temporarily restricted net assets, end of year	$ 9,104,210	$ 7,103,337
CHANGES IN PERMANENTLY RESTRICTED NET ASSETS:		
Permanently restricted contributions	$ 132,933	$ 54,812
Permanently restricted net assets, beginning of year	16,033,467	15,978,655
Permanently restricted net assets, end of year	$ 16,166,400	$ 16,033,467
Increase in net assets	$ 39,686,074	$ 31,876,710
Net assets, beginning of year	184,533,902	152,657,192
Net assets, end of year	$ 224,219,976	$ 184,533,902

See notes to consolidated financial statements.

EAST TENNESSEE CHILDREN'S HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

	Year Ended June 30,	
	2013	*2012*
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	$ 39,686,074	$ 31,876,710
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	7,970,424	7,332,047
Net gain on disposal of assets	(9,580)	(586,041)
Equity in earnings of joint venture	(1,030,899)	(799,110)
Restricted contributions	(5,406,484)	(4,016,196)
Amortization of bond discount	12,298	-
Increase (decrease) in cash due to changes in:		
Patient accounts receivable, net	2,935,390	914,732
Other receivables, net	196,885	(326,603)
Inventories and prepaid expenses	(305,786)	(346,732)
Trading securities	(45,623,108)	(29,922,118)
Other assets	(3,300)	(209,385)
Accounts payable and accrued expenses	(118,298)	1,517,841
Accrued compensation, benefits and payroll taxes	985,890	762,846
Estimated payable to third-party payers, net	1,668,198	992,422
Other long-term and estimated professional liabilities	(110,000)	-
Total adjustments	(38,838,370)	(24,686,297)
NET CASH PROVIDED BY OPERATING ACTIVITIES	847,704	7,190,413
CASH FLOWS FROM INVESTING ACTIVITIES:		
Capital expenditures, net	(7,310,787)	(5,513,092)
Proceeds from disposal of property, plant and equipment	23,718	868,775
Decrease (increase) in assets limited as to use	24,397	(38,121)
Payments received on notes receivable	179,594	235,979
Increase in notes receivable	(50,152)	(7,155)
Cash paid for acquisition of physician practices and related assets	-	(339,292)
Distributions from joint venture	934,628	809,683
NET CASH USED IN INVESTING ACTIVITIES	(6,198,602)	(3,983,223)

	Year Ended June 30, 2013	2012
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt	(1,100,000)	(1,050,000)
Restricted contributions	5,406,484	4,016,196
NET CASH PROVIDED BY FINANCING ACTIVITIES	4,306,484	2,966,196
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(1,044,414)	6,173,386
CASH AND CASH EQUIVALENTS, beginning of year	33,505,835	27,332,449
CASH AND CASH EQUIVALENTS, end of year	$ 32,461,421	$ 33,505,835
Reconciliation of cash and cash equivalents on Consolidated Statements of Cash Flows to the Consolidated Balance Sheets:		
Cash and cash equivalents - unrestricted	$ 32,461,421	$ 32,228,925
Cash restricted by donors for long-term purposes	-	1,276,910
	$ 32,461,421	$ 33,505,835
SUPPLEMENTAL INFORMATION:		
Cash paid for interest	$ 2,200,800	$ 2,249,175
Restricted contribution accrual	$ 54,691	$ 264,801

During 2012, the Hospital acquired the assets of certain physician practices. The physician practices are consolidated within the accompanying consolidated financial statements as of the respective acquisition dates. The consolidated cash flows include the practices' cash flows since the acquisition dates.

NOTE A--THE ENTITY

Operations: East Tennessee Children's Hospital Association, Inc. (the Hospital) is a 152-bed, not-for-profit acute care pediatric hospital located in Knox County, Tennessee. The Hospital is the sole shareholder or sole member of the following subsidiaries:

East Tennessee Children's Hospital Primary Care Center, Inc. (Primary Care), a taxable not-for-profit entity established in 1995 as a holding company for Children's Primary Care Center, the Pediatric Clinic, Boys and Girls Pediatrics, Maryville Pediatric Group, Oak Ridge Pediatric Clinic, Greene Mountain Pediatrics, Greeneville Pediatrics and Children's Faith Pediatrics. Other than Children's Primary Care Center, all pediatric clinics are practices acquired by the Hospital. The clinics are located throughout Knox, Blount, Anderson, Loudon, Campbell, Greene and Sevier Counties in Tennessee.

Collector's, Inc. of Knoxville (CIK), a for-profit collection agency. During 2005, the operations of CIK were absorbed into and became a department of the Hospital. Management does not intend to permanently dissolve CIK.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The consolidated financial statements include the accounts of the Hospital and its subsidiaries after elimination of all significant intercompany accounts and transactions. For purposes of display, transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are reported as revenues and expenses. Peripheral or incidental transactions are reported as other gains (losses).

Use of Estimates: The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from these estimates. Significant estimates subject to change in the near term include estimated contractual adjustments, estimated allowance for uncollectible accounts, estimated payable to third-party payers, net and estimated professional liabilities.

Cash and Cash Equivalents: Cash and cash equivalents include non-designated investments with original terms to maturity of approximately three months or less when purchased. Cash and cash equivalents designated as assets limited as to use, restricted by donors for long-term purposes or uninvested amounts included in investment portfolios are not included in the Consolidated Balance Sheets as cash and cash equivalents.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Inventories: Inventories are carried at the lower of cost or market utilizing the first-in, first-out method.

Trading Securities and Investment Income: Trading securities are reported at fair value based on quoted market prices of identical or similar securities. Realized gains and losses on trading securities are computed using the specific identification method for cost determination. Investment income (including unrealized and realized gains and losses) on unrestricted funds are reported as a part of other gains (losses). Estimated earnings (including unrealized and realized gains and losses) on temporarily restricted net assets are allocated to that net asset classification (Note C). Investment income is reported net of related investment fees.

Assets Limited as to Use: Investments held by a trustee under the terms of bond indentures are reported as assets limited as to use. Assets limited as to use that are required for obligations classified as current liabilities or amounts to be paid during the subsequent year are reported as current assets.

Property, Plant and Equipment: Property, plant and equipment is stated at cost or, if donated, at the fair market value at the date of the gift. Depreciation is computed by the straight-line method over the estimated useful lives of the buildings and improvements (5 to 40 years) and equipment (3 to 20 years). Renewals and betterments are capitalized and depreciated over their estimated useful lives, whereas repair and maintenance expenditures are expensed as incurred. The Hospital reviews capital assets for indications of potential impairment when there are changes in circumstances related to a specific asset. The Hospital did not recognize any impairment losses in 2013 or 2012.

Deferred Financing Costs: Deferred financing costs are amortized over the term of the respective debt issue utilizing the straight-line method. Deferred financing costs are net of accumulated amortization of $540,837 and $487,640 at June 30, 2013 and 2012, respectively.

Intangible Asset: The intangible asset relates to patient relationships acquired in the purchase of a physician practice.

Investment in Joint Venture: The investment in joint venture is recorded on the equity method of accounting (Note J).

Temporarily and Permanently Restricted Net Assets: Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Excess of Revenue, Gains and Support Over Expenses and Losses: The Statements of Operations and Changes in Net Assets includes the caption Excess of Revenue, Gains and Support Over Expenses and Losses (the Measurement). Contributions of long-lived assets (including assets acquired using contributions which, by donor restriction, were to be used for the purposes of acquiring such assets) are excluded from the Measurement.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts, including estimated retroactive adjustments under reimbursement agreements with certain third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Patient accounts receivable are reported net of both an estimated allowance for uncollectible accounts and an allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicaid, TennCare and other third-party payment programs. Current operations include a provision for bad debts estimated based upon the age of the patient accounts receivable, historical writeoffs and recoveries and any unusual circumstances (such as local, regional or national economic conditions) which affect the collectibility of receivables, including management's assumptions about conditions it expects to exist and courses of action it expects to take. Additions to the allowance for uncollectible accounts result from the provision for bad debts. Patient accounts written off as uncollectible are deducted from the allowance for uncollectible accounts. Patient service revenue is recorded prior to assessing the patient's ability to pay and as such, the estimated provision for bad debts is recorded as a deduction from patient service revenue, net of contractual allowances in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

The Hospital's policy does not require collateral or other security for patient accounts receivable. The Hospital routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

Receipts from the State of Tennessee under the TennCare Essential Access, Disproportionate Share and Trauma Care programs are recognized as net patient service revenue when such amounts can be reasonably estimated.

Charity Care: The Hospital provides healthcare services and other financial support through various programs that are designed to enhance the health of children in the community and foster medical education and research. The Hospital's financial assistance policy is designed to provide care to patients regardless of their ability to pay. Patients who meet certain criteria for charity care are

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

provided healthcare without charge. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, charges at established rates are not reported as revenue. Charges foregone, based on established rates, totaled approximately $962,000 and $1,132,000 in 2013 and 2012, respectively. The estimated direct and indirect cost of providing these services totaled approximately $368,000 and $446,000 in 2013 and 2012, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated under a reasonable and systematic approach.

Donor Restricted Gifts: Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. Resources restricted by donors for specific operating purposes are held as temporarily restricted net assets until expended for the intended purpose, at which time they are reported as "net assets released from restrictions used for operations." Resources restricted by donors for additions to property, plant and equipment (or payments on debt incurred for property additions) are held as temporarily restricted net assets until expended, at which time they are reported as "net assets released from restrictions used for the purchase of property, plant and equipment or principal payments on long-term debt."

Gifts, grants and bequests not restricted by donors are reported as unrestricted donations. The majority of unconditional promises to give and other support receivables are expected to be received within twelve months.

Endowments: The Hospital's endowment consists of fifteen individual funds established by donors for a variety of purposes. The Board of Directors of the Hospital has interpreted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are expended in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, the Hospital considers various factors in making a determination to appropriate or accumulate donor-restricted endowment funds, such as the duration and preservation of the fund, the purposes of the Hospital and the donor-restricted endowment fund, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the organization and the investment policies of the Hospital.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Federal Income Taxes: The Hospital is classified as an organization exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been included in the accompanying consolidated financial statements related to the 501(c)(3) organization. Primary Care and CIK are taxable entities and account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note M). The Hospital has no uncertain tax positions at June 30, 2013 or 2012. At June 30, 2013, tax returns for 2009 through 2013 are subject to examination by the Internal Revenue Service.

Fair Value of Financial Instruments: The carrying value of substantially all financial instruments approximates fair value due to the nature or term of the instruments, except for long-term debt (Note O).

Subsequent Events: The Hospital evaluated all events or transactions that occurred after June 30, 2013, through September 18, 2013, the date the consolidated financial statements were available to be issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2013 consolidated financial statements, other than as discussed in Note P.

New Accounting Pronouncements: In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2011-07, *Healthcare Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and Allowance for Doubtful Accounts for Certain Healthcare Entities*, which requires certain healthcare entities to reclassify the provision for bad debts associated with providing patient care from an operating expense to a deduction from net patient service revenue in the Consolidated Statements of Operations and Changes in Net Assets. Additionally, ASU 2011-07 requires enhanced disclosures about an entity's policies for recognizing revenue and assessing bad debts and qualitative and quantitative information about changes in the allowance for doubtful accounts. The Hospital retroactively adopted ASU 2011-07 in fiscal year 2013. The adoption of ASU 2011-07 did not have a material impact on the 2013 or 2012 consolidated financial statements.

Reclassifications: Certain 2012 amounts have been reclassified to conform with the 2013 presentation in the accompanying consolidated financial statements.

NOTE C--TRADING SECURITIES AND ASSETS LIMITED AS TO USE

Assets limited as to use under bond indenture agreements and assets required to be used for debt service are summarized by type as follows as of June 30:

NOTE C--TRADING SECURITIES AND ASSETS LIMITED AS TO USE - Continued

	2013	2012
Cash equivalents	$ 3,424,264	$ 5,566,661
U.S. government securities	2,118,000	-
	5,542,264	5,566,661
Less: amount required to meet current liabilities	(2,238,120)	(2,204,600)
Non-current assets limited as to use	$ 3,304,144	$ 3,362,061

Trading securities, at fair value, are summarized by type as follows as of June 30:

	2013	2012
Marketable equity securities	$ 53,130,254	$ 36,869,503
U.S. government securities	4,568,678	3,730,652
U.S. agency securities	16,973,150	15,895,794
Corporate debt securities	45,387,600	29,669,503
Municipal bond securities	10,976,168	4,466,904
Cash equivalents	7,711,211	2,491,596
	138,747,061	93,123,952
Less: securities classified as restricted by donors for long-term purposes	(20,673,412)	(18,498,407)
Trading securities	$ 118,073,649	$ 74,625,545

Income on trading securities and assets limited as to use is comprised of the following for the years ending June 30:

	2013	2012
Interest and dividend income, net of fees	$ 3,415,160	$ 1,204,232
Net realized (losses) gains on the sale of securities	(1,221,410)	348,368
Change in net unrealized gain on securities	3,988,116	267,055
	$ 6,181,866	$ 1,819,655

The Hospital allocates certain investment earnings to temporarily restricted net assets. The allocated income is comprised of the following for the years ending June 30:

NOTE C--TRADING SECURITIES AND ASSETS LIMITED AS TO USE - Continued

	2013	*2012*
Interest and dividend income, net of fees	$ 654,390	$ 839,734
Change in net unrealized gain on securities	1,705,205	(32,403)
	$ 2,359,595	$ 807,331

The trading portfolio, (including securities restricted by donors for long-term purposes) had a net unrealized gain of approximately $9,797,000 at June 30, 2013 and a net unrealized gain of approximately $4,104,000 at June 30, 2012.

NOTE D--PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment at June 30 is summarized as follows:

	2013	*2012*
Land	$ 8,545,188	$ 8,532,057
Building and improvements	93,533,821	92,123,849
Equipment	58,617,339	54,453,880
Construction in progress	-	386,496
	160,696,348	155,496,282
Less: Accumulated depreciation	(84,436,122)	(78,747,508)
	$ 76,260,226	$ 76,748,774

Depreciation expense for the years ended June 30, 2013 and 2012 was approximately $7,770,000 and $7,266,000, respectively.

NOTE E--LONG-TERM DEBT

During 2003, the Hospital issued $50,000,000 of Hospital Revenue Refunding and Improvement Bonds (the 2003 Bonds). The 2003 Bonds consist of $25,060,000 of Series A (insured) term bonds (the Series A bonds); $18,755,000 of Series B term bonds (the Series B term bonds) and $6,185,000 of Series B serial bonds (the Series B serial bonds). Certain proceeds from the issuance of the 2003 Bonds, net of issuance costs and discounts, were deposited into trust accounts for future capital projects and construction period interest payments. Certain other amounts were deposited into a debt service reserve fund, as required by the Master Trust Indenture dated February 15, 2003, as

NOTE E--LONG-TERM DEBT - Continued

additional security for bond holders. Further, approximately $6,490,000 was deposited into a trust account under an Escrow Deposit Agreement for the purpose of paying principal, interest and applicable call premiums on previously issued debt. The 2003 Bonds are secured by an interest in the gross revenues of the Hospital and Primary Care.

The following is a summary of long-term debt as of June 30:

	2013	*2012*
Revenue Bonds, 2003, Series A, issued through the Health, Educational and Housing Facility Board of Knox County, Tennessee; consisting of term bonds totaling $25,060,000, bearing interest of 5% with required annual sinking fund payments ranging from $1,405,000 to $2,555,000, beginning in 2018 through 2030.	$ 25,060,000	$ 25,060,000
Revenue Bonds, 2003, Series B, issued through the Health, Educational and Housing Facility Board of Knox County, Tennessee; consisting of remaining serial bonds of $1,150,000, bearing interest of 4.75% maturing in 2014; and term bonds totaling $15,600,000 bearing interest at rates ranging from 5.00% to 5.75% with required sinking fund payments ranging from $1,205,000 to $3,205,000 through 2034.	16,750,000	17,850,000
	41,810,000	42,910,000
Less: unamortized discount	(266,175)	(278,473)
Less: current portion	(1,150,000)	(1,100,000)
	$ 40,393,825	$ 41,531,527

The maturities of the outstanding debt at June 30, 2013 are as follows for the years ending June 30:

2014	$ 1,150,000
2015	1,205,000
2016	1,270,000
2017	1,335,000
2018	1,405,000
Thereafter	35,445,000
	$ 41,810,000

Under the terms of the bond indenture, the Hospital is required to maintain certain deposits with a trustee which are included as part of assets limited as to use. The Hospital is also subject to certain

NOTE E--LONG-TERM DEBT - Continued

affirmative and negative covenants, including maintenance of specific debt service coverage ratios. The Hospital believes it is in compliance with these covenants at June 30, 2013.

NOTE F--TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Temporarily restricted net assets are available for the following purposes at June 30:

	2013	*2012*
Healthcare services:		
Purchases of equipment and debt service	$ 4,536,331	$ 4,006,652
Research and education	1,990,026	1,501,466
Indigent care and other	2,577,853	1,595,219
	$ 9,104,210	$ 7,103,337

During 2013 and 2012, approximately $2,466,000 and $822,000, respectively, of temporarily restricted net assets were released from restrictions for the purchase of property and equipment. As discussed in Note E, the Hospital issued the 2003 Bonds in part for the purposes of funding significant renovations to the Hospital facility. The Hospital also solicited donations to supplement the funding of this project. During 2013, approximately $804,000 was released from these temporarily restricted donations for the purpose of funding principal payments on the 2003 Bonds; no such amounts were released in 2012.

Net assets released from restrictions related to fundraising activities were approximately $1,016,000 and $1,181,000, respectively, for the years ended June 30, 2013 and 2012.

At June 30, 2013 and 2012, permanently restricted net assets of $16,166,400 and $16,033,467, respectively, are held as endowments. The principal of the endowments will be held to perpetuity consistent with donor restrictions. Income from the endowments is expendable to support healthcare services or to purchase equipment for the operation of the Hospital.

The Hospital has adopted investment policies for endowment assets which attempt to preserve capital, maximize the return within reasonable and prudent levels of risk, and provide a return to the restricted funds. Endowment assets are invested in a manner that is intended to produce results that exceed the initial recorded value of the investment and yield a targeted long-term rate of return while assuming a moderate level of investment risk.

NOTE F--TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS - Continued

Changes in endowment net assets for the years ended June 30, 2013 and 2012 are as follows:

	Temporarily Restricted	*Permanently Restricted*	*Total*
Endowment net assets, July 1, 2011	$ 1,606,151	$ 15,978,655	$ 17,584,806
Investment earnings:			
Interest and dividend income, net of fees	401,561	-	401,561
Net realized/unrealized gains on investments	284,387	-	284,387
Total investment earnings	685,948	-	685,948
Contributions	76,585	54,812	131,397
Appropriation of endowment assets for expenditure	(89,024)	-	(89,024)
Endowment net assets, June 30, 2012	2,279,660	16,033,467	18,313,127
Investment earnings:			
Interest and dividend income, net of fees	578,166	-	578,166
Net realized/unrealized gains on investments	1,596,839	-	1,596,839
Total investment earnings	2,175,005	-	2,175,005
Contributions	34,462	132,933	167,395
Appropriation of endowment assets for expenditure	(136,991)	-	(136,991)
Endowment net assets, June 30, 2013	$ 4,352,136	$ 16,166,400	$ 20,518,536

NOTE G--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations and Changes in Net Assets is as follows for the years ended June 30:

	2013	*2012*
Inpatient service charges	$ 222,826,251	$ 216,304,313
Outpatient service charges	232,950,246	212,546,199
Gross patient service charges	455,776,497	428,850,512
Less:		
Estimated contractual adjustments	244,248,354	224,177,217
Charity care	962,359	1,131,609
Estimated provision for bad debts	3,691,343	4,110,085
	248,902,056	229,418,911
Net patient service revenue	$ 206,874,441	$ 199,431,601

NOTE G–NET PATIENT SERVICE REVENUE - Continued

Patient service revenue, net of contractual allowances is composed of the following for the years ended June 30:

	2013	*2012*
Third-party payers	$ 206,504,403	$ 200,217,951
Patients	4,061,381	3,323,735
Patient service revenue	$ 210,565,784	$ 203,541,686

Patient deductibles and copayments under third-party payment programs are included within the patient amounts above.

Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary, for expected uncollectible deductibles and copayments on accounts for which the third-party payer has not paid or for payers who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with patients, which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financial responsible. The difference between rates and the amounts actually collected after all reasonable collections efforts have been exhausted is charged against the allowance for uncollectible accounts.

Estimated allowances for uncollectible accounts decreased approximately $3,520,000 during the year ended June 30, 2013. The decrease is consistent with an 11% decline in gross patient accounts receivable.

During the years ended June 30, 2013 and 2012, net patient service revenue of approximately $16,127,000 and $15,203,000, respectively, net of related physician fees of approximately $17,239,000 and $17,966,000, respectively, is included in professional fees and services in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

NOTE H--THIRD-PARTY REIMBURSEMENT

The Hospital has agreements with various third-party payers that provide for payments to the Hospital at amounts different from established rates. The difference between the Hospital's rates and the estimated payments from third-party payers is recorded as a contractual allowance. Net patient service revenue and the related accounts receivable have been adjusted to the estimated amounts that will be received under third-party payer arrangements.

Amounts earned under certain of these contractual arrangements are subject to review and final determination by various program intermediaries and appropriate governmental authorities or their agents. Management believes that adequate provision has been made for any adjustments which may result from such reviews.

A summary of the payment arrangements with major third-party payers is as follows:

TennCare: Reimbursement under the State of Tennessee's Medicaid waiver program (TennCare) for inpatient and outpatient services is administered by various managed care organizations. TennCare reimbursement for inpatient and outpatient services is based upon diagnosis related group assignments, a negotiated per diem or a fee schedule basis. The Hospital also receives additional distributions from the State of Tennessee under the TennCare Essential Access program and other programs designed to provide supplemental funding for services provided to TennCare patients. Future distributions under these programs are not guaranteed. The amount recognized totaled approximately $4,460,000 and $2,131,000, respectively, in 2013 and 2012. The estimated payable to third-party payers, net in the accompanying Consolidated Balance Sheets at June 30, 2013 and 2012 includes approximately $2,800,000 and $1,096,000, respectively, related to supplemental funding which is subject to audit by the State of Tennessee and will be recognized when the Hospital's eligibility to receive such funding is confirmed. In addition, during 2013 the Hospital recognized approximately $2,415,000 from the TennCare Medicaid Provider Incentive Program related to the implementation and meaningful use of electronic medical records as provided by the Health Information Technology for Economics and Clinical Health (HITECH) act. Such payments are included within other operating revenue in the accompanying 2013 Consolidated Statement of Operations and Changes in Net Assets and are not guaranteed in future periods.

Effective, July 1, 2010, hospital providers in the State of Tennessee are subject to an annual assessment based upon a percentage of net patient revenue. The provider payments are matched with available federal funds and used to make payments back to providers. In fiscal years 2013 and 2012, assessments paid by the Hospital of approximately $5,804,000 and $5,801,000, respectively, were completely offset by payments received from the State of Tennessee. As such, no net amounts related to these assessments have been recognized in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

NOTE H--THIRD-PARTY REIMBURSEMENT - Continued

Other: The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined per diem rates.

NOTE I--RETIREMENT PLAN

The Hospital sponsors a 403(b) plan (the 403(b) Plan) which is funded solely by employees' contributions. The Hospital does not make any discretionary or matching contributions into the 403(b) Plan. In addition, the Hospital has a defined contribution plan (the Plan) under which the Hospital contributes from 2% to 4% of each eligible employee's salary, based on the employee's length of service. The contribution is limited to the first $250,000 of salary in each plan year. The Hospital also contributes to the Plan one-half of each employee's contributions to the 403(b) Plan, limited to two percent of eligible employee's salary each plan year. Employees are eligible to participate in the Plan after completion of one year of service in which the employee is credited with 1,000 hours of service and the employee has attained age 21. Contributions related to the Plan totaled approximately $3,214,000 and $2,843,000 in 2013 and 2012, respectively. The Hospital also sponsors a 457(f) plan for certain key executives and physician employees.

Notes Receivable and Other in the Consolidated Balance Sheets at June 30, 2013 and 2012 includes approximately $1,305,000 related to the Hospital's portion of benefits recoverable upon the death of individuals participating in a previous secured executive benefit program. The Hospital did not make any contributions into this program during 2012 or 2013 and the Hospital is not required to make any future contributions into this program.

NOTE J--RELATED PARTY TRANSACTIONS

The Hospital has entered into transactions with entities affiliated with certain members of the Board of Directors including transactions to renovate Hospital facilities and provide professional services, including investment management. Professional and other fees associated with Board members totaled approximately $2,402,000 and $1,381,000 in 2013 and 2012, respectively. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

Children's West Surgery Center (the Center): During 2000, the Hospital entered into a joint venture with a group of physicians to develop and operate a pediatric outpatient surgery center. Ownership is shared equally among the Hospital and physicians.

NOTE J--RELATED PARTY TRANSACTIONS - Continued

Unaudited, condensed financial information of the Center is as follows as of June 30, 2013 and for the six-month period then ended:

Assets	$ 2,256,253
Equity	$ 2,117,011
Net gain	$ 1,239,563

NOTE K--COMMITMENTS AND CONTINGENCIES

Insurance: The Hospital maintains general and professional liability insurance through a commercial insurance company. The general and professional liability insurance policies have $1,000,000 per claim coverage with an aggregate maximum coverage of $3,000,000 per annum, after a deductible of $100,000 per claim and an aggregate annual deductible of $700,000. In addition, the Hospital maintains an umbrella liability policy in the amount of $20,000,000. The policy coverages are on a claims-made basis. As part of the insurance plan, the Hospital is required to hold a $300,000 letter of credit for the benefit of the insurance company. This letter of credit was unused as of June 30, 2013.

At June 30, 2013, the Hospital is involved in litigation relating to medical malpractice arising in the ordinary course of business. There are also known incidents occurring through June 30, 2013 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Hospital management has estimated and accrued for the cost of asserted claims based on historical data and legal counsel advice. No accrual for claims incurred but not reported is recorded in the accompanying consolidated financial statements as management is not able to estimate such amounts.

The Hospital also maintains worker's compensation insurance through a commercial carrier. The policy has a $250,000 per occurrence and a $1,200,000 aggregate annual deductible. The Hospital is required to hold a $450,000 letter of credit for the benefit of the insurance company. This letter of credit was unused as of June 30, 2013. Hospital management has estimated and accrued for the cost of asserted claims based on historical data. No accrual for claims incurred but not reported is recorded in the accompanying consolidated financial statements as management is not able to estimate such amounts.

Employee Benefits: The Hospital is self-insured for health claims under a health insurance program and has purchased reinsurance for individual claims exceeding $150,000 annually. Claims payable, as well as management's estimate for claims incurred but not reported is included as part of accounts

NOTE K--COMMITMENTS AND CONTINGENCIES - Continued

payable and accrued expenses in the accompanying Consolidated Balance Sheets. At June 30, 2013 and 2012, no amounts were recoverable from the reinsurance carrier.

Physician Agreements: The Hospital enters into contractual relationships with physician practices to provide services to the community. Under the contracts, the Hospital has committed to provide advances to certain practices in various amounts. Certain of the contracts contain provisions that payments of the advances will be forgiven if the physicians continue to practice pediatric medicine in the community for specified terms. Further, upon termination of the contract for specified reasons, certain of the agreements require the Hospital to purchase professional liability tail coverage for the physician. Management estimates that the Hospital's liability related to purchasing the professional liability tail coverage is not significant as of June 30, 2013.

Compliance: The ever increasing compliance requirements placed on hospitals in general and the current implementation of the new Stark regulations in particular have far-reaching consequences. This has resulted in new initiatives by the Hospital to review and strengthen compliance requirements. The Board of Directors has a standing compliance committee which has been actively involved with management in reviewing all physician related contracts. In addition, the Hospital employs, as part of the management team, a Vice President for Legal Services and General Counsel. This individual is responsible for several areas, including compliance, contract coordination, and risk management. In addition to these compliance initiatives, management and the Board have adopted a vision, *Leading the Way to Healthy Children*, and have adopted a strategic plan that will guide the efforts of the Hospital over the next five years.

Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In March 2010, Congress adopted comprehensive healthcare insurance legislation, *Patient Care Protection and Affordable Care Act* and *Health Care and Education Reconciliation Act.* The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE L--CONCENTRATION OF CREDIT RISK

The Hospital is located in Knoxville, Tennessee and the Hospital grants credit without collateral to its patients, most of who are local residents insured under third-party payer agreements. Admitting physicians are primarily practitioners in the local area. Approximately 89% of the consolidated entity's net patient service revenue is related to the operations of the acute care hospital in 2013 and 2012.

A significant portion of the Hospital's support is related to contributions and other support from the local community. As such, the Hospital has a concentration of risk related to these contributions.

The mix of gross receivables from patients and third-party payers are as follows as of June 30:

	2013	*2012*
TennCare	44%	58%
Medicaid	4%	5%
Commercial and other	49%	34%
Patients	3%	3%
	100%	100%

The Hospital maintains bank accounts at various financial institutions covered by the Federal Deposit Insurance Corporation (FDIC). At times throughout the year, the Hospital may maintain bank account balances in excess of the FDIC insured limit. Management believes the credit risk associated with these deposits is not significant.

The Hospital routinely invests its surplus operating funds in investment vehicles as listed in Note C. Investments in marketable equity securities, corporate debt, municipal bonds and money market funds are not insured or guaranteed by the U.S. government; however, management believes that credit risk related to these investments is minimal.

NOTE M--INCOME TAXES

Primary Care and CIK account for income taxes under the provisions of ASC 740, *Income Taxes*. As of June 30, 2013, Primary Care has net operating loss carryforwards for federal and state income tax purposes of approximately $31,300,000 related to operating losses generated in the current and prior years which expire in years 2013 through 2031. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and Tennessee Code Annotated. Deferred income taxes reflect the net tax effects of temporary

NOTE M--INCOME TAXES - Continued

differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes.

The components of Primary Care's deferred taxes at June 30, 2013 and 2012 consist of deferred tax assets of approximately $4,703,000 and $4,418,000, respectively, related to net operating loss carryforwards. Primary Care has established a valuation allowance which completely offsets all recorded deferred tax assets at June 30, 2013 and 2012. The valuation allowance of Primary Care increased by approximately $285,000 in 2013, due primarily to the 2013 net operating loss. The Hospital did not recognize any income tax expense or benefit related to Primary Care in the years ending June 30, 2013 and 2012.

NOTE N--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

The Hospital does not present expense information by functional classification because its resources and activities are primarily related to providing healthcare services. Further, since the Hospital receives substantially all of its resources from providing healthcare services in a manner similar to business enterprise, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged their stewardship responsibilities.

NOTE O--FAIR VALUE MEASUREMENT

FASB ASC 820 establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 - Inputs based on quoted market prices for identical assets or liabilities in active markets at the measurement date.

- Level 2 - Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active; or other inputs that are observable or can be corroborated by observable market data.

- Level 3 - Inputs reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date. The inputs are unobservable in the market and significant to the instrument's valuation.

NOTE O--FAIR VALUE MEASUREMENT - Continued

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Hospital's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded on a recurring basis (assets) and non-recurring basis (long-term debt) at fair value or disclosed at fair value as of June 30, 2013 and 2012:

	June 30, 2013	*Level 1*	*Level 2*	*Level 3*
Marketable equity securities	$ 53,130,254	$ 53,130,254	$ -	$ -
U.S. government securities	6,686,678	6,686,678	-	-
U.S. agency securities	16,973,150	-	16,973,150	-
Corporate debt securities	45,387,600	-	45,387,600	-
Municipal bond securities	10,976,168	-	10,976,168	-
Cash equivalents	11,135,475	11,135,475	-	-
Total assets	$ 144,289,325	$ 70,952,407	$ 73,336,918	$ -
Fair value of long-term debt	$ 40,262,000	$ -	$ 40,262,000	$ -

	June 30, 2012	*Level 1*	*Level 2*	*Level 3*
Marketable equity securities	$ 36,869,503	$ 36,869,503	$ -	$ -
U.S. government securities	3,730,652	3,730,652	-	-
U.S. agency securities	15,895,794	-	15,895,794	-
Corporate debt securities	29,669,503	-	29,669,503	-
Municipal bond securities	4,466,904	-	4,466,904	-
Cash equivalents	8,058,257	8,058,257	-	-
Total assets	$ 98,690,613	$ 48,658,412	$ 50,032,201	$ -
Fair value of long-term debt	$ 43,367,000	$ -	$ 43,367,000	$ -

NOTE P--SUBSEQUENT EVENT

In August 2013, the Hospital issued a $37,465,000 fixed rate tax-exempt Hospital Revenue Refunding Bond (2013 Bond) through The Health, Educational and Housing Facility Board of the

NOTE P--SUBSEQUENT EVENT - Continued

County of Knox County, Tennessee. The proceeds from the 2013 Bond will be used to refinance the 2003 Bonds. The 2013 Bond matures in July 2033 and is subject to acceleration of the maturity date, at the option of the purchaser, in July 2023.

Attachment C, Contribution to the Orderly Development of Health Care-7(d) Inspection Report Plan of Correction

10 2009

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

May 18, 2009

Keith Goodwin, Administrator
East Tennessee Children's Hospital
2018 Clinch Avenue
Knoxville TN 37916

Dear Mr. Goodwin:

The East Tennessee Regional Office of Health Care Facilities conducted a licensure survey at your facility on March 16-18, 2009. On April 2, 2009, an acceptable Plan of Correction was received in this office.

A revisit was completed May 11, 2009, to verify that your facility has achieved and maintained compliance. Based on our revisit, we found that your facility has demonstrated compliance with the deficiencies cited.

If you have any questions, please contact the East Tennessee Regional office at (865) 588-5656.

Sincerely,

Faye Vance / djm

Faye Vance, R.N., B.S., M.S.N.
Public Health Nurse Consultant Manager

FV/ djm

POST-LICENSURE REVISIT REPORT Hospital	LICENSE NUMBER TNP5341	DATE OF REVISIT 5-11-09
NAME OF FACILITY East Tennessee Childrens Hospital	STREET ADDRESS, CITY, STATE, ZIP CODE 2018 Clinch Ave Knoxville TN 37916	

This report is completed by a qualified State surveyor for the Tennessee Licensure programs, to show those deficiencies previously reported on the Licensure Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using the regulation number previously shown on the Licensure Statement of Deficiencies and Plan of Correction Form. If all deficiencies are not corrected, the surveyor should check the block at the bottom right of this form indicating the need for the completion of the Licensure-5, Summary of Deficiencies Not Corrected.

ITEM	DATE	ITEM	DATE	ITEM	DATE
1200-8-1-.08(1)	Correction Completed 5/11/09	1200-8-1-.08(3)	Correction Completed 5/11/09	1200-8-1-.08(23)	Correction Completed 5/11/09
1200-8-1-.09(2)	Correction Completed 5/11/09	1200-8-1-.14(1)(9)	Correction Completed 5/11/09	1200-_____	Correction Completed / /
1200-_____	Correction Completed / /	1200-_____	Correction Completed / /	1200-_____	Correction Completed / /
1200-_____	Correction Completed / /	1200-_____	Correction Completed / /	1200-_____	Correction Completed / /
1200-_____	Correction Completed / /	1200-_____	Correction Completed / /	1200-_____	Correction Completed / /

REVIEWED BY STATE AGENCY ☐	REVIEWED BY: (INITIALS)	DATE	SIGNATURE OF STATE SURVEYOR	DATE
			Stuart	5/11/09

FOLLOWUP TO SURVEY COMPLETED ON	TITLE
3-17-09	FSS I

Form Licensure-3
RS-3151
RCF 5/88

☐ SEE ATTACHED LICENSURE FORM FOR ANY UNCORRECTED DEFICIENCIES

J/kav A/5

24 2009

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGIONAL OFFICE
5904 LYONS VIEW PIKE, BLDG 1
KNOXVILLE, TENNESSEE 37919

23 March 2009

Keith Goodwin, Administrator
East Tennessee Children's Hospital
2018 Clinch Avenue
Knoxville TN 37916

Dear Mr. Goodwin:

Enclosed is a Statement of Deficiencies which was developed as a result of the annual licensure survey conducted at your facility on **March 16-18, 2009**. Corrective action must be achieved **prior to May 2, 2009**, the 45th day from the date of survey. A revisit may be conducted to verify compliance.

Please develop a Plan of Correction for the deficiencies cited and return by **April 2, 2009**. Failure to provide an acceptable plan of correction by **April 2, 2009**, could result in a referral to the Board of Licensing Health Care Facilities for whatever action they deem appropriate.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficiency practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

In the column "Completion Date" of the State Form 2567, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the state form 2567.

If you have any questions, please contact this office at (865) 588-5656 or by fax at (865) 594-5739.

Sincerely,

Faye Vance /djm

Faye Vance, R.N., B.S., M.S.N.
Public Health Nurse Consultant Manager

FV / djm

Enclosure: Statement of Deficiencies

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53141	A BUILDING _____ B WING _____	03/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
EAST TENNESSEE CHILDRENS HOSPITAL	2018 CLINCH AVE SW KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 643	1200-8-1- 06 (3)(g) Basic Hospital Functions (3) Infection Control. (g) The facility and its employees shall adopt and utilize standard precautions (per CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include: 1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each patient contact if hands are not visibly soiled; 2. Use of gloves during each patient contact with blood or where other potentially infectious materials, mucous membranes, and non-intact skin could occur and gloves changed before and after each patient contact; 3. Use of either a non-antimicrobial soap and water or an antimicrobial soap and water for visibly soiled hands; and 4. Health care worker education programs which may include: (i) Types of patient care activities that can result in hand contamination; (ii) Advantages and disadvantages of various methods used to clean hands; (iii) Potential risks of health care workers ' colonization or infection caused by organisms acquired from patients; and (iv) Morbidity, mortality, and costs associated with health care associated infections.	H 643		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT/CEO — (X6) DATE: 4/2/09

Division of Health Care Facilities

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H 643	Continued From page 1 This Rule is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure infection control practices were maintained in the Emergency Department (ED), the Neonatal Intensive Care Unit (NICU), and the Pediatric Intensive Care Unit (PICU) The findings included: Observation, at the nurse's station in the ED, on March 16, 2009, at 2:10 p.m., revealed Registered Nurse (RN) #2; with ungloved hands, carrying a specimen container filled with urine RN #2 picked up a medical record; removed a self adhesive patient identification sticker from the medical record; placed the sticker on the specimen container; and placed the specimen container in a biohazard bag. Interview, at the nurse's station of the ED, on March 16, 2009, at 2:10 p.m , with RN #2, confirmed the specimen container filled with urine was to be placed in a biohazard bag prior to removing the container from the patient room; and the hands were to be washed prior to exiting the patient room. Observation, in the NICU, on March 17, 2009, at 10:45 a m , revealed RN #3, with gloved hands, obtained and placed pipettes and a lancet from the bedside drawer on top of the uncovered bedside table; removed a soiled dressing from the foot of an infant; picked up the lancet and pierced the left heel of the infant; picked up the pipettes and obtained blood from the heel of the infant; picked up and placed a cotton ball on the heel of the infant; obtained a roll of tape from the	H 643	H643 - Staff education and remediation on Hand Hygiene and Infection Control Standards is being communicated to all staff via electronic communication Biohazard bags have been placed in patient rooms, so that labeled specimens can be placed in the bag and carried from the room Proper handwashing before leaving the patient room has been reinforced ED Management Team members will be rounding and observing these practices during each scheduled shift. Findings will be documented on Rounding sheets and reviewed monthly with follow up for outliers H643 - Staff education and remediation regarding hand hygiene and Infection Control Standards and appropriate use and disposal of PPE, as well as proper sequence managing patient care activities (i e clean to dirty) is being shared with staff Supplies, including lancet and pipettes, will be placed on soft net or sterile 2 X 2 instead of placing on surface of bedside table QI will be done by anonymous observation on a weekly basis: In addition, NICU management will be rounding and observing these practices during each scheduled shift Staff will also participate in QI of their own practice during each scheduled shift QI will be monitored weekly until three consecutive months of compliance at 100% recorded At that time, QI will be moved to a monthly basis	05/02/09 05/02/09

Division of Health Care Facilities

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H 643	Continued From page 2 bedside drawer; and taped the cotton ball in place on the heel of the infant RN #3 then removed the gloves from the hands. Interview, in the NICU, on March 17, 2009, at 10:45 a.m , with RN #3, confirmed the bedside table was not cleansed before the procedure; the gloves were not removed and hands washed/sanitized after removing a soiled dressing; and the gloves were not changed and hands not washed/sanitized between clean and dirty activities. Observation, in the PICU, on March 17, 2009, at 9:10 a.m , revealed RN #5, with gloved hands, changed an infant's soiled diaper; and without removing the soiled gloves, placed a pacifier in the infant's mouth and wiped the infant's eyes. RN #5 then removed the gloves, and without washing the hands, handled the infant's medical record, handled a writing pen, and touched the drawers to the bedside table. Interview, in the PICU, on March 17, 2009, at 9:10 a.m , with RN #5, confirmed the soiled gloves were to be removed and the hands washed/sanitized after changing the soiled diaper and before placing the pacifier in the infant's mouth and wiping the infant's eyes; and the hands were to be washed/sanitized after the removal of the gloves. Review of facility policies revealed "IC (infection control): Isolation, General Principles.. hand washing is the single most important means of preventing the spread of infection.. Gloves do not replace the need for good hand washing. ." and "Management of hand hygiene ..regulation for hand washing disinfection to decrease the spread of micro-organisms...provide personnel with efficacious hand-hygiene products . products	H 643	H643 - Staff education and remediation regarding hand hygiene, Infection Control Standards and appropriate use and disposal of PPE, as well as proper sequence managing patient care activities (i e clean to dirty) Appropriate hand cleaner dispensers are at all bedsides in the unit QI will be done by an anonymous observation on a weekly basis In addition, PICU management will be rounding and observing these practices during each scheduled shift Staff will also participate by the expectation that they QI their own practice during each scheduled shift Ongoing data collection with weekly reporting consideration will be given for monthly reporting after a three-month compliance rate of 100%	05/02/09

Division of Health Care Facilities

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H 643	Continued From page 3 used before and after patient care in clinical areas. "	H 643		
H 676	1200-8-1-.06 (4)(c) Basic Hospital Functions (4) Nursing Services (c) The nursing service must have adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care to all patients as needed There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to assess vital signs prior to a procedure for one (#8) of nineteen patients reviewed. The findings included: Patient #8 was admitted to the facility on March 16, 2009, for a Bone Marrow Biopsy. Medical record review of the Sedation Record dated March 16, 2009, revealed a 'Pre-Procedure' section with written direction to obtain vital signs within 5 minutes of the procedure Medical record review of the section for heart rate, respiratory rate, blood pressure, level of consciousness, and oxygen saturation, revealed written, "UTA anxiety!" Interview with the Nurse Manager of Outpatient Clinics on March 17, 2009, verified 'UTA' is an acronym for 'unable to obtain.' Continued interview with the Nurse Manager confirmed the facility failed to obtain vital signs per policy prior administration of	H 676	H676 - Staff education will be provided regarding policy of documenting patient assessment within an appropriate time frame prior to administration of sedation Pre-procedure vital signs will be added to the Sedation Quality Management form and monitored on a monthly basis Clinic staff will complete a sedation QI form at the end of each work day and tabulate weekly for three months and then monthly	05/02/09

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H 676	Continued From page 4 sedation for the procedure.	H 676		
H 678	1200-8-1- 06 (4)(e) Basic Hospital Functions (4) Nursing Services. (e) A registered nurse must assess, supervise and evaluate the nursing care for each patient. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure assessments were documented as required for a patient in restraints for one (#12) of nineteen patient reviewed. The findings included: Patient #12 was admitted to the facility on March 3, 3009, with diagnosis of Respiratory Distress. Medical record review revealed the patient had an Endotracheal tube (for breathing); intravenous tubes (to administer fluids/medications); a feeding tube (to provide nourishment); and drains (to provide an outlet for bodily fluids). Medical record review revealed the patient required the use of bilateral hand restraints to prevent the patient from dislodging the tubes. Medical record review revealed the restraints were in use beginning on March 3, 2009, at 1:30 p.m., and continued through March 13, 2009, at 4:48 p m Medical record review revealed the every two hour nursing assessments were not documented as follows: March 7, 2009, from 2:20 a m. until 8:00 a m. (6 hours); March 8, 2009, from 12:34 p.m. until 4:00 p.m. (3 ½ hours); and March 9, 2009, from 12:30 a m until 4:00 a.m. (3 ½ hours). Interview, at the Pediatric Intensive Care Unit	H 678	H678 - Staff re-education regarding the appropriate documentation for restraint application and assessment, via certified email In order to best remind staff to document the assessment process every two hours, the intervention for reassessment for restraints will be electronically added to the regular PICU assessment screen Staff will be prompted to document the restraint status and assessment at each regular patient assessment interval QI monitoring will be weekly, with consideration for monthly reporting given after a three-month period of 100% compliance	05/02/09

Division of Health Care Facilities

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H 678	Continued From page 5 (PICU) nurse's station, on March 17, 2009, at 9:50 a.m., with the PICU Manager and the Director of the Emergency Department, confirmed the facility policy for nursing assessment every two hour for restraint use was not followed.	H 678		
H 683	1200-8-1-.06 (4)(j) Basic Hospital Functions (4) Nursing Services. (j) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Rule is not met as evidenced by: Based on observation, manufacturer's recommendations, and interview, the facility failed to ensure emergency equipment in the Radiology Department; and failed to ensure intravenous and irrigation fluids, infant formula, and cereal in the Emergency Department (ED), available for patient use, were monitored to ensure equipment was ready for use or not available beyond the expiration date The finding included: Observation, in the Radiology Department Moderate Sedation prep room, on March 16, 2009, at 8:55 a.m., revealed the Emergency Cart Equipment Checklist, dated March 2009, had no documentation the equipment had been checked since March 4, 2009 (16 days).	H 683	H683 - The emergency cart check will be done at the end of each day The Radiology Director will confirm weekly that the cart checks are being done	03/18/09

Division of Health Care Facilities

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H 683	Continued From page 6 Interview, in the Radiology Department Moderate Sedation prep room, on March 16, 2009, at 8:55 a.m., with the Director of the Radiology Department, confirmed the equipment was to be checked daily. Observation, in the ED Fast Track supply area, on March 17, 2009, at 1:00 p.m., revealed the following expired infant formula: one 2 oz bottle (named) formula - dated January 1, 2009; two 2 oz bottles (named) infant formula - dated March 1, 2009; six 3 oz bottles (named) sterile water - dated November 12, 2008. Interview, in the ED Fast Tract supply area, on March 17, 2009, at 1:00 p m., with the Director of the ED, confirmed the infant formula was available for patient use and had expired Observation, in the ED, on March 17, 2009, at 1:30 p.m., revealed the warmer contained the following: one 1000 ml bottle (named) sodium chloride for irrigation - undated; one 500 ml bottle (named) bottle sodium chloride for irrigation - undated; three 500 ml bags of (named) sodium chloride intravenous fluids (IVF) - undated; one 500 ml bag sodium chloride IVF - dated February 27, 2009 (18 days); and one 500 ml bag (named) dextrose 5 lactated ringers - dated February 2, 2009 (43 days). Review of manufacturer's recommendations revealed ". Solutions for injection and irrigation . may be warmed...for a period no longer than two weeks (14 days)..." Interview, in the ED, on March 17, 2009, at 1:30 p.m., with the Director of the ED, confirmed the solutions were available for patient use and were to be dated and removed within 14 days of being placed in the warmer.	H 683	H683 - Staff education and awareness of the situation with expired formula in the department was communicated via electronic communication. In addition to Food Services' routine check of stocked formula supplies, the ED will now add these materials to the routine checks done monthly in the department ED management will monitor for compliance with these checks by spot-checking formula dates on the 15th of each month H683 - A policy using the manufacturer's recommendations for warming and storage of fluids was completed and forwarded to Pharmacy for review on 3/24/09 Staff education on warmed fluids and unit procedures for rotating fluids will be completed The warmer will be checked for safe temperature daily The warmer will be checked for outdated fluids on the 1st and 15th of each month ED management will monitor the warmer check log for compliance with the outlined plan	05/02/09 05/02/09

Division of Health Care Facilities

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H 683	Continued From page 7 Observation, in the ED patient nourishment cabinet of the Urgent Care area, on March 17, 2009, at 2:10 p.m , revealed a box of (named) infant oatmeal cereal with an expiration date of May 17, 2007 Interview, in the ED, on March 17, 2009, at 2:10 p m , with the Director of the ED, confirmed the (named) oatmeal cereal was available for patient use and had expired.	H 683	H683 - Staff education and awareness of the situation with expired formula in the department was communicated via electronic communication. In addition to Food Services' routine check of stocked formula supplies, the ED will now add these materials to the routine checks done monthly in the department ED management will monitor for compliance with these checks by spot-checking formula dates on the 15th of each month	05/0209
H 703	1200-8-1-.06 (5)(k)5. Basic Hospital Functions (5) Medical Records. (k) All records must document the following: 5 Properly executed informed consent forms for procedures and treatments specified by hospital policy, or by federal or state law if applicable, as requiring written patient consent; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure a properly executed consent was obtained prior to treatment and sedation for one patient (#5) of nineteen patients reviewed The findings included: Patient #5 was admitted on March 16, 2009, for a "VCU (bladder visualization) with sedation..." as an outpatient radiology procedure. Medical record review revealed the patient received Versed (sedative) 8.5 mg by mouth on March 16, 2009, at 8:32 a.m. Medial record review of the form "General Consent to Hospital and/or Medical Treatment" revealed the area indicating consent	H 703	H703 - All consents for treatment are confirmed prior to any procedure A statement for checking that the consent has been obtained will be added to the pre-procedure screening of the Anxiolysis Assessment and Orders Policy The Radiology Director will monitor weekly on a sample basis	03/19/09

Division of Health Care Facilities

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H 703	Continued From page 8 for treatment, diagnostic procedures, and anesthesia had not been signed. Interview, in the Radiology Sedation Suite, on March 16, 2009, at 9:20 a.m , with Registered Nurse (RN) #4, confirmed the RN had not checked the consent form to ensure authorization for the procedure and sedation had been signed.	H 703		
H 708	1200-8-1-.06 (6)(a) Basic Hospital Functions (6) Pharmaceutical Services (a) The hospital must have pharmaceutical services that meet the needs of the patients and are in accordance with the Tennessee Board of Pharmacy statutes and regulations. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital ' s organized pharmaceutical service. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were properly secured in the Emergency Department (ED). The findings included: Observation, on March 16, 2009, at 2:30 p.m., at the ED nurse's station in the Critical Area, revealed the unlocked medication refrigerator contained a plastic box, measuring approximately 1 ½ " X 12" X 6", with a plastic snap off lock. Located in the box were the following medications: Atropine (decreases secretions and prevents decreased heart rate); Versed (sedative); Fentanyl (sedative/analgesic);	H 708	H708 - Discussion was held with the Pharmacy Director to determine the best procedure to secure but provide rapid access to this kit. The kit was moved to the ED's Omnicell System to allow controlled access to this drug kit in a rapid fashion The Omnicell system allows management reporting of access to the kit for QI monitoring	03/25/09

Division of Health Care Facilities

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H 708	Continued From page 9 Rocuronium (paralytic agent); Vecuronium (paralytic agent); and Succinycholine (paralytic agent). Interview, at the nurse's station, on March 16, 2009, at 2:30 p.m., with the Director of the ED, confirmed the medications were not secured from unauthorized access.	H 708		

Division of Health Care Facilities

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	TNP53141	A BUILDING 77 - MAIN BUILDING 01 B WING	03/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
EAST TENNESSEE CHILDRENS HOSPITAL	2018 CLINCH AVE SW KNOXVILLE, TN 37916

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H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient This Rule is not met as evidenced by: Item #1) Based on observation and interview, the facility failed to assure the required clear space is maintained in front of electrical panels (NFPA 70, 110-16(d)). The findings include: Observation and interview with the Engineering Department Manager on March 16, 2009, at 1:45 p.m., confirmed five soiled linen carts in a corridor in front of electrical panels. Item #2) NFPA 101 Life Safety Code, 2003 Edition 19 3.6.3 Corridor Doors. 19.3.6.3.5 Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 22 N (5 lbf) is applied at the latch edge of the door.; (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.3. Based on observation and interview, the facility failed to assure corridor doors closed to a positive latch. The findings include:	H 871	H871 - Linen carts will be relocated	05/01/09

Division of Health Care Facilities

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	TNP53141	A. BUILDING 77 - MAIN BUILDING 01 B. WING _____	03/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TENNESSEE CHILDRENS HOSPITAL	2018 CLINCH AVE SW KNOXVILLE, TN 37916

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H 871	Continued From page 1 Observation and interview with the Engineering Department Manager on March 16, 2009, at 2:15 p.m., confirmed the Neurology unit storage room and the fire rated door adjacent to X-ray #5 failed to close to a positive latch. Item #3) NFPA 101 Life Safety Code, 2003 Edition 8.3.5.1 Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E-814 or ANSI/UL 1479 at a minimum positive pressure differential of 2.5 N/m2 (0.01 in. water column) between the exposed and the unexposed surface of the test assembly Standard Building Code, 1999 Edition Chapter 7 Fire Resistant Materials and Construction 701.2.5 Where materials, systems or devices incorporated into a fire resistant assembly have not been tested as part of the assembly, sufficient data shall be made available to the building official to show that the required fire resistant rating is not reduced Materials and methods of construction used to protect joints and penetrations in the fire resistant building assemblies shall not reduce the required fire resistant rating Based on observation and interview, the facility failed to assure smoke/fire barriers and rated floor/structural assemblies are maintained.	H 871	H871 - Neurology door warped New door to be installed and adjusted. Door ordered 3/27/09 X-Ray door adjusted for positive latch	04/21/09

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	TNP53141	A. BUILDING 77 - MAIN BUILDING 01 B. WING	03/17/2009

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	Continued From page 2 The findings include: Observation and interview with the Engineering Director on March 17, 2009, between 8:00 a.m. and 10:00 a.m., confirmed penetrations not sealed with an approved firestop system around communication wiring and pipes as well as removed fireproofing in the following locations: 1) 3r clinic electrical room 2) 3E electrical room conduit in floor 3) 3E communications closet 4) Main communications equipment room 5) Above ceiling 6th floor, above fire rated doors to the OR suite 6) Above ceiling at PACU double doors, above the exit sing 7) Above ceiling at PACU soiled utility room and fire door at same location has a large unsealed area around conduit over the door. 8) Above ceiling at 3 E-W fire rated door by respiratory care office 9) Emergency Department soiled utility room above ceiling 10) Ground floor outside biohazard room has a foam-like sealant around piping in the ceiling that was not identified as an approved firestop product. 11) 5th floor West soiled utility room, above ceiling 12) 4th floor linen chute room, above ceiling 13) 2nd floor soiled utility room, above ceiling 14) Ground floor, two hour fire rated wall near B elevators, adjacent to the kitchen 15) Ground floor, corridor wall in front of C elevators, above ceiling 16) Various small areas with fireproofing scraped from structural steel in the 3E mechanical room and mechanical rooms on the ground floor.	H 871	H871 - Penetrations listed 1-14 will be sealed prior to 5/1/09 #15 sealed 3/24/09 #16 fireproofing to be replaced by 4/13/09 The facility will establish and implement an above-the-ceiling work permit system to allow for work to be inspected after completion and before payment	05/01/09

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53141	A. BUILDING 77 - MAIN BUILDING 01 B. WING _____	03/17/2009

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H 871	Continued From page 3 Item # 4) NFPA 72 National Fire Alarm Code, 2002 Edition 5.7.4.1 In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors. Based on observation and interview, the facility failed to assure smoke detectors were located at least 3 feet from an air supply. The findings include: Observation and interview with the Engineering Manager on March 16, 2009, at 10:15 a.m., confirmed the smoke detector in the volunteer services refrigerator closet was six (6) inches from an air supply. Item #6) NFPA 13 Standard for the Installation of Sprinkler Systems, 2002 Edition 9 1.1.7 Support of Non-System Components. Sprinkler piping or hangers shall not be used to support non-system components. Based on observation and interview, the facility failed to assure the sprinkler system is installed in accordance with NFPA 13 with piping not be used to support non-system components The findings include: Observation and interview with the Engineering Manager on March 16, 2009, at 2:30 p.m., confirmed the ground floor communications room was not provided with sprinkler coverage. Observation and interview with the Engineering Manager on March 17, 2009, at 9:30 a m., confirmed wiring above the lay-in ceiling was	H 871	H871 - Smoke detector relocated	03/23/09
			H871 - Communication room sprinkler head installed	03/27/09

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H 871	Continued From page 4 supported by the sprinkler piping above ceiling at the 6th floor fire rated doors to PACU, 3W by the environmental services closet, and on the ground floor corridor outside the laundry area. Item #7) NFPA 101 Life Safety Code, 2003 Edition 19.7.5.7 Soiled linen or trash collection receptacles shall not exceed 121 L (32 gal) in capacity, and the following also shall apply: (1) The average density of container capacity in a room or space shall not exceed 20.4 L/m2 (0.5 gal/ft2).; (2) A capacity of 121 L (32 gal) shall not be exceeded within any 6-m2 (64-ft2) area ; (3) Mobile soiled linen or trash collection receptacles with capacities greater than 121 L (32 gal) shall be located in a room protected as a hazardous area when not attended.; (4) Container size and density shall not be limited in hazardous areas. Based on observation and staff interview, the facility failed to assure soiled linen or trash receptacles exceeding 32 gallons in capacity were located in a room protected as hazardous when not attended The findings include: Observation with the Engineering Manager on March 16, 2009, at 10:30 a m. confirmed five (5) soiled linen/ trash/ biohazard containers exceeding 32 gallons total capacity in the Emergency Department corridor and not in a protected room. Item #8) NFPA 1 Uniform Fire Code, 2003 Edition Chapter 63 Compressed Gases and Cryogenic Fluids 63.3.1.3.4 Securing Compressed Gas	H 871	H871 - Wiring above ceiling at locations will be secured off sprinkler pipes H871 - Linen carts will be relocated	05/01/09 05/01/09

Division of Health Care Facilities

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H 871	Continued From page 5 Containers, Cylinders, and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or a fixed object by use of a restraint, unless otherwise permitted by the following [55:7.1.3.4] NFPA 99 Standards for Health Care Facilities, 2002 Edition 5.1.4.8.4 Zone valve boxes shall be installed where they are visible and accessible at all times. 5.1.9.3.1 Area alarms shall be located at a nurse's station or other location that will provide for continuous responsible surveillance 5.1 3.3 2 Design and Construction. Locations for central supply systems and the storage of medical gases shall meet the following requirements: (1) Be constructed with access to move cylinders, equipment, and so forth, in and out of the location (2) Be secured with lockable doors or gates or otherwise secured (3) If outdoors, be provided with an enclosure (wall or fencing) constructed of non-combustible materials (4) If indoors, be constructed and use interior finishes of non-combustible or limited-combustible materials such that all walls, floors, ceilings and doors are of a minimum 1-hr fire resistance rating (5) Be compliant with NFPA 70, National Electrical Code, for ordinary locations, with electrical devices located at or above 1520 mm (5 ft) above finished floor to avoid physical damage (6) Be heated by indirect means (e.g., steam, hot water), if heat is required (7) Be provided with racks, chains, or other fastenings to individually secure all cylinders,	H 871		

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H 871	Continued From page 6 whether connected, unconnected, full, or empty, from falling (8) Be supplied with electrical power compliant with the requirements for essential electrical systems as described in Chapter 4 of this document (9) Have racks, shelves, and supports, where provided, constructed of non-combustible materials or limited-combustible materials. 9.4.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) compressed shall comply with the requirements in 9.4.2(A) through (C). (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour (D) Liquefied gas container storage shall comply with 5.1.3.4.10. (E) Cylinder and container storage locations shall meet 5.1.3.3.1.7 with respect to temperature limitations. (F) Electrical fixtures in storage locations shall meet 5.1.3.3.2(5).	H 871		

Division of Health Care Facilities

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H 871	Continued From page 7 (G) Cylinder protection from mechanical shock shall meet 5.3.13 2 3. (H) Cylinder or container restraint shall meet 5.3.13 2.3 (I) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6 1 m (20 ft) of outside storage locations. (J) Cylinder valve protection caps shall meet 5.3.13.2 3 (K) Gas cylinder and liquefied gas container storage shall comply with 5.1.3.4 10 Based on observation, the facility failed to assure stored gas cylinders are secured from falling, medical gas alarm panels and zone valves are accessible, and medical gas storage enclosures are constructed and maintained in accordance with NFPA 99, Standards for Health Care Facilities, and NFPA 1 Uniform Fire Code. The findings include: Observation and interview with the Director of Engineering and Security and Engineering Manager on March 16, 2009, confirmed three H size cylinders were stored without cylinder caps in the manifold room adjacent to the cafeteria, three small CO2 cylinders were stored in the kitchen without a means to secure from falling; twelve unsecured oxygen cylinders in the ground floor gas storage room, as well as the roof medical gas manifold room and the ground floor gas storage room had electrical outlets and switches less than five feet from the floor. Observation and interview further confirmed an enclosure with greater than 300 cubic feet of medical gases was located in an exit access path from the Nursery Suite and this enclosure did not meet the requirements for medical gas storage enclosures.	H 871	H871 – Cylinder caps replaced H871- CO2 cylinders secured by chains H871 - Electrical outlets were relocated by raising to proper height H871 - Ground floor tanks secured H871 - Tanks at exit path will be relocated.	03/16/09 03/25/09 03/23/09 03/26/09 04/03/09

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H 871	Continued From page 8 Observation and interview further confirmed accessibility and observation of the medical gas zone valve and medical gas alarm panel is obstructed by carts and racks in the Nursery Suite. Item #9) NFPA 101 Life Safety Code, 2003 Edition 7.5 Arrangement of Means of Egress. 7 5.1 General 7.5.1 1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 19.2.3 5 The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Based on observation, the facility failed to assure the means of egress is maintained readily accessible at all times The findings include: Observation and interview with the Director of Engineering and Security on March 16, 2009, confirmed two of three exits from the Nursery Suite were obstructed by equipment to include a cart, chart rack, 2 drawer cabinet, five shelf metal cart filled with supplies, a rolling computer, storage cart, and a linen collection cart. The third exit from the suite required passage through an enclosure used for medical gas storage, exceeding 300 cubic feet.	H 871	H871 - Cart relocated to clear panel H871- Exit paths will be cleared and unit manager informed about requirements	03/29/09 04/17/09
H 873	1200-8-1-.08 (3) Building Standards (3) No new hospital shall hereafter be constructed, nor shall major alterations be made to existing hospitals, or change in hospital type be	H 873		

Division of Health Care Facilities

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H 873	Continued From page 9 made without the prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new hospital is licensed or before any alteration or expansion of a licensed hospital can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure alterations to the facility are made with prior approval from the Department of Health. The findings include: Observation and interview with the Director of Engineering and Security on March 16, 2009, between 9:00 a m. and 4:00 p.m., confirmed various exit doors throughout the facility were locked with magnetic locking hardware and the facility failed to obtain prior approval from the Department of Health for the installation of special locking hardware	H 873	H873- List of doors will be compiled and sent to Department of Health in Nashville	04/08/09
H 893	1200-8-1-.08 (23) Building Standards (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be	H 893		

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H 893	Continued From page 10 maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Guidelines for the Design and Construction of Hospital and Health Care Facilities, 1996-97 Edition Table 2 Ventilation Requirements for Areas Affecting Patient Care in Hospitals and Outpatient Facilities: Physical Therapy and hydrotherapy, Air movement relationship to adjacent areas = In Based on observation and interview, the facility failed to assure required relative air pressures are maintained for specific facility spaces The findings include: Observation and interview with the Engineering Manager, on March 16, 2009, at 10:00 a.m., confirmed the 4W rehabilitation room was not under a negative air pressure.	H 893	H893 - Air handler rebalanced AHU and system adjusted and balanced to achieve proper pressure relationship	03/27/09
H 902	1200-8-1-.09 (2) Life Safety (2) The hospital shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for hospital personnel in each separate patient-occupied hospital building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire	H 902		

PRINTED: 03/19/2009
FORM APPROVED

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H 902	Continued From page 11 department shall be reported to the department within seven (7) days The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire Initial reports by the facility may omit the name(s) of patient(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information. Authority: T.C A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure fire extinguishers were provided to be accessible in all areas within a travel distance of 75 feet (NFPA 10). The findings include: Observation and interview with the Engineering Department Manager on March 16, 2009, at 2:00 p.m., confirmed the Pharmacy and medical record room were not provided with a portable fire extinguisher. The portable fire extinguishers in the corridor were greater than 75 feet travel distance	H 902	H902 - Fire extinguishers installed in the Pharmacy and Medical Records	03/18/09
H1401	1200-8-1-.14 (1)(a) Disaster Preparedness (1) Emergency Electrical Power. (a) All hospitals must have one or more on-site electrical generators which are capable of	H1401		

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H1401	Continued From page 12 providing emergency electrical power to at least all life sustaining equipment and life sustaining resources such as: ventilators; blood banks, biological refrigerators, safety switches for boilers, safety lighting for corridors and stairwells and other essential equipment This Rule is not met as evidenced by: NFPA 110 Standard for Emergency and Standby Power Systems, 2002 Edition Chapter 7 Installation and Environmental Considerations 7.3 Lighting. 7.3.1 The Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access Based on observation and interview, the facility failed to assure battery powered emergency lighting is provided at emergency electrical source equipment locations. The findings include: Observation and interview with the Director of Engineering and Security on March 16, 2007, confirmed the room containing the generator transfer switch and the room containing the generator was not provided with battery powered emergency lighting.	H1401	H1401 - Battery powered lights installed in generator and transfer rooms	03/30/09

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P 002	1200-8-30 No Deficiencies During the annual Licensure survey conducted on March 16-18, 2009, at East Tennessee Children's Hospital, no deficiencies were cited under chapter 1200-8-30, Standards for Pediatric Emergency Care Facilities.	P 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: PRESIDENT/CEO

(X6) DATE: 4/2/09

Proof of Publication

NOTICE TO FURNISHERS OF LABOR AND MATERIALS TO:
Rogers Group, Inc.
PROJECT NO.: 47030-3225-94
CONTRACT NO.: CNK954
COUNTY: Knox

The Tennessee Department of Transportation is about to make final settlement with the contractor for construction of the above numbered project. All persons wishing to file claims pursuant to Section 54-5-122, T.C.A. must file same with the Director of Construction, Tennessee Department of Transportation, Suite 700 James K. Polk Bldg., Nashville, Tennessee 37243-0326, on or before 02/14/14.

NOTICE TO FURNISHERS OF LABOR AND MATERIALS TO:
LoJac, Inc.
PROJECT NO.: 98018-4109-04
CONTRACT NO.: CNK494
COUNTY: Knox

The Tennessee Department of Transportation is about to make final settlement with the contractor for construction of the above numbered project. All persons wishing to file claims pursuant to Section 54-5-122, T.C.A. must file same with the Director of Construction, Tennessee Department of Transportation, Suite 700 James K. Polk Bldg., Nashville, Tennessee 37243-0326, on or before 02/14/14.

NOTICE TO FURNISHERS OF LABOR AND MATERIALS TO:
Law Signs, LLC
PROJECT NO.: 47100-4112-04
CONTRACT NO.: CNM069
COUNTY: Knox

The Tennessee Department of Transportation is about to make final settlement with the contractor for construction of the above numbered project. All persons wishing to file claims pursuant to Section 54-5-122, T.C.A. must file same with the Director of Construction, Tennessee Department of Transportation, Suite 700 James K. Polk Bldg., Nashville, Tennessee 37243-0326, on or before 02/14/14.

NOTICE TO CREDITORS

ESTATE OF PAUL R. FRENO
DOCKET NUMBER 74463-1

Notice is hereby given that on the 31st day of December, 2013, letters testamentary in respect of the Estate of PAUL R. FRENO who died Nov 17, 2013, were issued the undersigned by the Clerk and Master of the Chancery Court of Knox County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured, against his or her estate are required to file the same with the Clerk and Master of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred.

(1)(A) Four (4) months from the date of the first publication of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of this first publication; or

(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication as described in (1) (A); or

(2) Twelve (12) months from the decedent's date of death.

This the 31st day of December, 2013.

Estate of PAUL R. FRENO

PERSONAL REPRESENTATIVE(S):
Linda J. Jaekel; Executrix
12021 Broken Saddle Road
Knoxville, TN 37934

Publish: 1/3/14 and 1/10/14

NOTICE TO CREDITORS

ESTATE OF DORIS LUCILLE HOBBY
DOCKET NUMBER 74440-2

Notice is hereby given that on the 31st day of December, 2013, letters administration in respect of the Estate of DORIS LUCILLE HOBBY who died Aug 4, 2013, were issued the undersigned by the Clerk and Master of the Chancery Court of Knox County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured, against his or her estate are required to file the same with the Clerk and Master of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred.

(1)(A) Four (4) months from the date of the first publication of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of this first publication; or

(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication as described in (1) (A); or

(2) Twelve (12) months from the decedent's date of death.

This the 31st day of December, 2013.

Estate of DORIS LUCILLE HOBBY

PERSONAL REPRESENTATIVE(S):
Linda A. Whitley; Administratrix
6000 Fayette Lane
Knoxville, TN 37924

Publish: 1/3/14 and 1/10/14

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that:

East Tennessee Children's Hospital, Hospital owned by: East Tennessee Children's Hospital Association, Inc. with an ownership type of Non-profit corporation and to be managed by itself intends to file an application for a Certificate of Need for renovation and expansion of the NICU, Neonatal Abstinence Syndrome Unit, Perioperative Services, and Specialty Clinic located on the Hospital's campus at 2018 Clinch Avenue, Knoxville, TN 37916. The licensed beds are not affected, no services will be initiated, and no major medical equipment will be purchased as a result of this project. The estimated project costs are $75,300,000.

The anticipated date of filing the application is: January 15, 2014.

The contact person for this project is Kim Harvey Looney, Attorney, who may be reached at: Waller Lansden Dortch & Davis LLP, 511 Union Street, Suite 2700, Nashville, TN 37219, 615-850-8722.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Public Notice

As required by 40 CFR 51.160 et seq. the Knox County Department of Air Quality Management is providing the public opportunity to review and comment on two draft construction permits.

Aqua-Chem Inc requested new operational limits and recordkeeping requirements for their facility located at 3001 E. John Sevier Highway, Knoxville, TN 37914.

Farragut Cleaners Inc applied to construct a petroleum dry cleaning machine at their facility located at 11185 Kingston Pike, Knoxville, TN 37934.

To be considered, written comments must be submitted to the Department at the following address by February 10, 2014.

Knox County
Department of Air Quality Management
140 Dameron Avenue
Knoxville, TN 37917

These draft construction permits are available for review at the Department offices during regular business hours. For further information please call (865) 215-5900.

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Contact Gene: 865-938-5888 ext 2
Knoxville, TN
gene@jabezexp.com

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Friday – Wednesday, 2 p.m.
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RK SHOWS PRESENTS GUN SHOW Jan. 25-26 SAT 9-5 & SUN 9-4
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Saturday, Jan. 11, from 9 am to 1 pm. Furniture, appliances, household items, dishes, clothes.

ESTATE SALE
Fri. 3-7pm, Sat. 9-3pm. 7508 Gyneverе, 37931. Tag sale in home + 50 items bidding online. Furn., sterling, collectibles, JIH, + costume jewelry & comic book collections. For info and bidding see SevenlevelEstateSales.com

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NISSAN TRUCK '96 4 cyl. 5-speed, AC, Aluminum Wheels $3950 KARS INC. 865-689-2190

CHEV SILVERADO 2500 HD 2003, 6.0L, auto, ext cab, 4x4, step bars, Michelins, 147K mi, super clean, $12,800 865-414-7480

DODGE RAM 1500 SLT quad 1998, 4x4, 139K mi., V8, 5.9L mtr, Runs Great! $5000, 865-473-4897.

FORD F150 2009 Platinum crew, 4x4, htd & cooled lthr, nav, sroof, loaded, 91K mi $27,800 David @ 865-414-7480

FORD F150 2011 XLT crew, 4x4, only 27K mi, phone console, custom camper top, one owner, $30,800 call 865-414-7480

FORD F150 2008 diesel, ext cab, FX4, all pwr, 4x4, 20" wheels, 77K miles $25,800 David @ 865-414-7480

FORD SVT RAPTOR 2011 crew, 4x4, 6.2L, V8, many options, 32K miles, $45,800 David @ 865-414-7480

GMC SIERRA 3500 2003 diesel, dually, 4x4, crew cab, lthr, all pwr, alloys, step bars, 116K mi, $16,500 David @ 865-414-7480

Corvette Convertible 1966, 327 / 350, 4 sp, blk / yellow, grad driver, $49K firm. 865-254-1992

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SUPPLEMENTAL-1

East TN Children's Hospital

CN1401-002

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Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966

615.244.6380 main
615.244.6804 fax
wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

SUPPLEMENTAL- # 1
January 30, 2014
3:00pm

January 30, 2014

VIA HAND DELIVERY

Phillip M. Earhart
HSD Examiner
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Certificate of Need Application CN1401-002
East Tennessee Children's Hospital

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated January 24, 2014, wherein additional information or clarification was requested regarding the above-referenced CON application.

---

1. **Section A., Applicant Profile, Item 4**

   The East Tennessee Children's list of Board of Directors as of 2009 is noted. Please clarify if this list is currently accurate.

   Response: The current board of directors for ETCH is: Dee Haslam (Chairman), Larry Martin (Vice Chairman), Michael Crabtree (Secretary/Treasurer), John Buchheit, M.D., Mark Cramolini, M.D., Randall Gibson, Keith Goodwin, Steven Harb, Lewis Harris, M.D., Gale Huneycutt, Jr., David Martin, Chris Miller, M.D., David Nickels, M.D., Laura Palenkas, Steve South, and Andrea Anne White.

2. **Section A., Applicant Profile, Item 13**

   Please clarify if the applicant is currently contracted with BlueCare, TennCare Select, United Healthcare Community Plan, and AmeriGroup. It was unclear in the application if the applicant has already contracted, or plans to contract with these organizations.

   Response: The applicant currently contracts with these managed care payors.

3. **Section B.II.A., Project Description**

   Please describe neonatal abstinence syndrome (NAS).

Response: Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb. Babies of mothers who drink during pregnancy may have a similar condition. At birth, the baby is still dependent on the drug. Because the baby is no longer getting the drug after birth, symptoms of withdrawal may occur.

The applicant states the NAS baby occurrence is anticipated to decline. What are the factors involved and projected rates of decline?

Response: The applicant cannot accurately predict the rate of decline, but is hoping to discourage the use of drugs or alcohol in pregnant women. To decrease the incidence of alcohol or drug use in pregnant women, the applicant works with the expectant mothers during prenatal care to educate them on the adverse effects of the substances on the unborn child to get them to discontinue the alcohol or drug use. When they are successful, the newborn is less likely to experience NAS.

What are the future plans for the 40,900 square feet of shelled space?

Response: The shelled space is intended to be used primarily for the expansion of outpatient clinical space and support space.

The applicant states the new building will be five stories. Is the structure built in a way to add additional stories in the future? If so, how many? If not, where will future expansion occur?

Response: The structure is not being built to accommodate additional stories in the future. The only future expansion that is currently planned is the shelled space described above. The expansion that is the subject of this application is expected to meet the needs of ETCH for the foreseeable future.

There appears to be calculation errors in the Square Footage and Cost per Square Footage Chart in the GSF subtotal for the proposed final square footage "renovated" and "total" columns. If needed, please resubmit.

Response: Please see the revised Square Footage and Cost Per Square Footage Chart included as Attachment B.II.A, Project Description.

Please total the existing square SF column of the Square Footage and Cost per Square Footage Chart.

Response: Please see revised Square Footage and Cost Per Square Footage Chart included as Attachment B.II.A, Project Description.

Please clarify if the East Tennessee Children's Hospital proposed expansion and renovation will meet or exceed the latest Tennessee Perinatal Care System, Guidelines for Regionalization Hospital Care Levels, Staffing and Facilities standards.

Response: The proposed renovation and expansion of ETCH will meet or exceed the latest Tennessee Perinatal Care System, Guidelines for Regionalization Hospital Care Levels, Staffing and Facilities standards.

Please clarify what will happen to the NICU unit area at the existing facility when it is relocated to the newly constructed hospital.

Response: As shown on the page of the floor plan labelled as CON-Level 5 Area Renovation, the existing NICU area will be used for support areas. These include respiratory care, family sleep suites, PICU support, NICU support, etc.

What will happen to existing ORs? How many ORs are there now, and how many will there be after completion of the project?

Response: The applicant currently operates 9 ORs and 3 endoscopy/pulmonology rooms. After completion of the project there will be 10 ORs and 4 procedure rooms (one of the ORs will be shelled space). After completion of the project, the renovated third floor will include unit support, an on call suite, satellite pharmacy, lab and other office support areas and the renovated sixth floor will include the neurology lab, and other laboratory and child life, social work and pastoral areas.

Please complete the following charts:

Current Building

Location	Description of Services	# of inpatient beds	Type of beds
Floor One	Outpatient & Ancillary Support	0	
Floor Two	Medical Services/ Outpatient Clinics	37	private
Floor Three	Medical Services/Clinic/NAS-NICU	42	26 private 16-NICU/NAS private
Floor Four	Outpatient & Inpatient Surgery; Inpatient Beds	16	private
Floor Five	NICU & PICU	57	44 NICU 13 PICU
Floor Six	Perioperative Services	0	
Total Beds		152	

Current Building after Completion of the Proposed Project

Location	Description of Services	# of inpatient beds	Type of beds
Floor One	Outpatient & Ancillary Support	0	
Floor Two	Medical Services/Clinic	34	Private
Floor Three	Medical Services	30	Private
Floor Four	NAS(NICU) Inpatient Surgery	31	16 NAS Private 15 Private
Floor Five	PICU & Family Support	13	10 Private 3 Semi-private
Floor Six	Lab & Neurology & Staff Support	0	
Total Beds		108	

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New Building

Location	Description of Services	# of inpatient beds	Type of beds
Floor One	Shell	0	
Floor Two	SPD & Outpatient Clinic	0	
Floor Three	Perioperative Services	0	
Floor Four	Lockers & Mechanical	0	
Floor Five	NICU	44	Private
Total Beds		44	
Total Beds After Project		152	

4. **Section B. III., Project Description (Plot Plan)**

Please submit a revised plot plan that reflects the size of the site.

Response: Please see plot plan which now has the acreage identified on the plan included as Attachment B.II, Project Description (Plot Plan).

5. **Section B. IV., Project Description (Floor Plan)**

The floor plan is noted. However, please note private and semi-private patient care rooms.

Response: The patient care rooms are identified with numbers. All rooms are private rooms unless they are identified with an S, which identifies the semi-private patient care rooms.

6. **Section C, Need, Item 1.**

STATE HEALTH PLAN

Tennessee Code Annotated Section 68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/finance/healthplanning/). The State Health Plan guides the state in the development of health care programs and policies and in the allocation of health care resources in the state, including the Certificate of Need program. The 5 Principles for Achieving Better Health form the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Each Principle is listed below with example questions to help the applicant in its thinking.

Response: The applicant addresses the 5 Principles for Achieving Better Health found in the State Health Plan below:

Principle 1: Healthy Lives

Response: The applicant seeks to assist its primary patient population by promoting access to its service for one of the most vulnerable patient populations: infant and children. In particular, it seeks to decrease the number of babies born with NAS. It is working to discourage the use of drugs or alcohol in pregnant women. To decrease the incidence of alcohol or drug use in pregnant women, the applicant works with the expectant mothers during prenatal care to educate them on the adverse effects of the substances on the unborn child to get them to discontinue the alcohol or drug use. When they are successful, the newborn is less likely to experience NAS.

Principle 2: Access to Care

Response: The applicant provides care to infants and children, one of the most fragile patient populations. It is the only freestanding children's hospital in the East Tennessee Perinatal Region, which includes the counties of Anderson, Blount, Hamblen, Jefferson, Knox, Loudon, Roane and Sevier (primary service area); and the counties of Union, Scott, Pickett, Morgan, Monroe, Grainger, Fentress, Cumberland, Cocke, Claiborne, and Campbell (secondary service area). Current ETCH facilities are at capacity. Over time, many family spaces in patient and public areas have been reduced or displaced to serve medical purposes. In some instances, the concept of patient and family centered care was not even incorporated into the planning, because the space was built so long ago. The facility is operating with outdated design spaces and outdated usage, which does not allow it to operate at maximum efficiency, which can hinder access to care. The facility can no longer accommodate necessary growth, updates or services. Children's hospitals have changed significantly since ETCH was built and any renovations were completed. Programs should not only focus on the health of the child, but should incorporate the family in patient care. The areas that are the primary focus of the renovation and expansion are the NICU, the surgical areas, and the NAS unit.

In the NICU, having private rooms will help meet the family's needs for sleeping accommodations while being present 24/7 in a more home-like environment, as compared to the current open layout. The all-private room design will accommodate rooming-in for parents with a sofa bed, storage space for family, and most importantly, a controlled environment for the baby and mother. References and research materials for family members during the stay are housed in the resource room which acts as a small

library and business center. This, in turn, will enhance parent education in preparation for being discharged. Family support amenities will be enhanced to reduce the impact of extended stays. The unit's family lounge will help parents during their stay by supplying a kitchen, showers, and laundry facilities. Along with decentralized stations, the new units will provide better direct observation of patients, increased responsiveness and presence of the medical team, and encourage closer relationships with the family.

Principle 3: Economic Efficiencies

Response: There will be no increase in costs to patients as a result of the expansion. Much of the renovation is focused on the provision of the services in the most efficient manner, which in turn should help to increase the economic efficiencies of the operation of the hospital. Some of the renovations which are expected to provide the greatest impact are also expected to increase access to care as well as increase quality of care and are discussed both above and below this response.

Principle 4: Quality of Care

Response: The applicant always seeks to provide the highest quality of care to its patient population. Much of the renovation and expansion is necessary in order for it to maintain its high quality of care. For example, the changes in the operation of the surgical units is expected to have a significant impact. The current perioperative services at ETCH are located on two levels, which can hinder the care provided; the proposed project will enable the applicant to consolidate the perioperative services on one floor. This bifurcated system is the result of growth without proper spatial accommodations, and requires elevator travel and handoffs with every patient transport. Patient spaces are not private, which is the current standard. Dedicated equipment storage is nonexistent, so surgical corridors are congested and partially blocked. There will be no new beds as a result of this expansion, but the areas need to be expanded to allow for best practices in pediatric care. The new operating rooms will meet or exceed the current standards for operating rooms; the existing ORs do not generally meet the space requirements. Keeping family informed of their child's progression through surgery, by means of tracking boards in designated public spaces, will allow families the freedom to leave the waiting room and alleviate potential anxiety and stress. Families will be notified when to be present for a post-op meeting with the surgeon/proceduralist, to be conducted in a private room, with comfortable furniture and media to illustrate the measures taken with each case. Overall quality of care will be enhanced from start-to-finish.

The applicant will provide residents in need of its services with a high quality of care regardless of their ability to pay.

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Principle 5: Health Care Workforce:

Response: The applicant operates with a well-trained health care workforce. It does not anticipate increasing the workforce as a result of this application. In addition, ETCH assists in the training of the future health care workforce through nursing schools and medical schools in the area. These training programs include the following Schools of Nursing: University of Tennessee, South College, Carson Newman College, Lincoln Memorial University, Tennessee Technological University, Tennessee Wesleyan, Walters State Community College, Roane State Community College, and Pellissippi State. The applicant also participates in resident rotations for the family practice program at ETSU's Quillen College of Medicine, medical student rotations at Lincoln Memorial University, and the surgical residency program at UT.

7. **Section C, Need, Item 4.A.**

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

SUPPLEMENTAL- # 1
January 30, 2014
3:00pm

waller

Response: The applicant provides the requested information below. It revised the format slightly to make the data easier to review and comprehend.

Variable	Current Year (CY) Age 65+	Projected Year (PY), Age 65+	Age 65+, % Change	Age 65+, % Total (PY)	CY, Total Population	PY, Total Population	Total Pop. % Change
TN	981,984	1,102,413	12.3	16.1	6,588,698	6,833,509	3.7
Service Area	230,334	258,207	12.1	19.1	1,300,552	1,353,068	4.0
Total SSA	64,149	68,450	6.7	20.5	324,374	334,024	3.0
Union	3,171	3,660	15.4	18.7	19,301	19,605	1.6
Scott	3,541	3,857	8.9	17.6	21,944	21,969	0.1
Pickett	1,292	1,369	6.0	27.7	5,019	4,943	(1.5)
Morgan	3,436	3,796	10.5	17.3	21,848	22,004	0.7
Monroe	8,938	10,340	15.7	21.5	46,092	48,088	4.3
Grainger	4,204	4,557	8.4	19.2	23,111	23,675	2.4
Fentress	3,566	3,870	8.5	20.4	18,404	18,987	3.2
Cumberland	15,838	15,630	(.01)	25.9	57,815	60,292	4.3
Cocke	6,669	6,871	3.0	17.8	36,762	38,615	5.0
Claiborne	5,880	6,378	8.5	19.2	32,604	33,280	2.1
Campbell	7,614	8,122	6.7	19.1	41,474	42,566	2.6
Total PSA	166,185	189,757	14.2	18.6	976,178	1,019,044	4.4
Knox	66,392	78,354	18.0	16.5	453,629	475,569	4.8
Sevier	16,768	19,252	14.8	19.2	94,833	100,362	5.8
Roane	11,422	12,508	9.5	23.0	54,006	54,457	.08
Loudon	12,711	14,179	11.5	26.7	50,926	53,192	4.4
Jefferson	9,972	11,291	13.2	19.9	53,729	56,872	5.8
Hamblen	11,269	12,067	7.1	18.4	64,108	65,570	2.3
Blount	23,120	25,829	11.7	19.1	128,368	135,171	5.3
Anderson	14,531	16,277	12.0	20.9	76,579	77,851	1.7

Source: TDH Population Projections, June 2013. TennCare Bureau October 2013 Enrollment Data; United States Census Bureau QuickFacts and American FactFinder Data.

*Average of median age, median household income, and percent below poverty level.

Variable	TennCare Enrollees	TennCare Enrollees as a % of Total Population	Median Age	Median Household Income	Population % Below Poverty Level
TN	1,197,411	18.3	38.0	44,140	17.3
Service Area	227,318	17.6	42.0*	37,694*	18.75*
Total SSA	76,826	23.8	42.3*	33,126*	21.1*
Union	4,411	22.9	40.1	33,456	22.6
Scott	7,067	32.1	38.1	29,161	25.8
Pickett	1,014	20.1	47.2	34,255	21.0
Morgan	4,227	19.4	39.8	37,522	19.1
Monroe	9,950	21.8	41.6	36,430	19.3
Grainger	5,004	21.8	42.1	33,185	20.2
Fentress	5,379	29.4	42.3	27,773	25.4
Cumberland	10,456	18.2	48.3	37,963	16.4
Cocke	9,882	27.2	42.9	29,764	16.0
Claiborne	7,873	24.3	41.1	33,568	23.0
Campbell	11,563	28.1	41.7	31,312	23.7
Total PSA	150,492	15.6	41.7*	43,976*	15.5*
Knox	62,986	14.1	37.2	47,270	14.2
Sevier	15,044	16.1	40.9	43,300	13.4
Roane	9,610	17.8	44.9	43,017	14.4
Loudon	7,011	13.9	46.0	49,602	14.6
Jefferson	10,114	19.1	40.8	38,800	19.2
Hamblen	13,192	20.7	39.6	39,316	18.6
Blount	18,695	14.7	41.4	46,347	12.7
Anderson	13,840	18.2	42.6	44,154	16.7

Source: TDH Population Projections, June 2013. TennCare Bureau October 2013 Enrollment Data; United States Census Bureau QuickFacts and American FactFinder Data.

*Average of median age, median household income, and percent below poverty level.

8. Section C, Need, Item 6

Please include detailed calculations or documentation from referral sources, and identification of all assumptions regarding the methodology in projecting utilization.

Please complete the following table for Surgical Trends and Utilization (Cases):

	Historical			Interim			Year 1	Year 2
	2011	2012	2013	2014*	2015	2016	2017	2018
IP Surgery	3,077	2,875	2,883	1,184	2,926	2,970	3,014	3,060
OP Surgery	7,875	7,969	8,035	3,405	8,155	8,277	8,401	8,527
Total Surgery	10,952	10,844	10,918	4,589	11,081	11,247	11,415	11,587

Source: East Tennessee Children's Hospital historical and projected hospital data.
*2014 July- November 2013

9. Section C, Economic Feasibility, Item 1

The letter supporting construction costs is noted. However please revise to include the project will meet all 2010 AIA standards, licensure rules, building codes, etc.

Response: Please see the revised contractor letter included as Attachment C, Economic Feasibility, Item 1.

10. Section C, Economic Feasibility, Item 2

It is noted the proposed project will be funded by tax-exempt bonds and cash reserves. Approximately what percentage will be funded by tax-exempt bonds and by cash reserves?

Response: The applicant anticipates that approximately $60 million will be issued in bonds and approximately $15 million will be funded from cash reserves.

11. Section C., Economic Feasibility, Item 4 (Historical and Projected Data Charts)

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Historical and Projected Data Charts provided as an attachment. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

There appears to be a typo on the Historical Data Chart in the Year 2011 for salaries and wages in the amount of $656,396,820. Please clarify.

Response: This was a typographical error and has now been corrected. In the process of reviewing the data on the historical and projected data charts, the applicant determined that some of the interest needed to be reclassified, so some entries are revised. However, the overall calculations are not affected. Please see the revised Historical Data Chart included as Attachment 11-12. C-Economic Feasibility, Item 4.

There appears to be calculation errors in the Year 2011 column of the Historical Data Chart, and in the calculation of the deductions from operating revenue for the years 2011 and 2013. Please revise.

Response: Please see the revised Historical Data Chart included as Attachment 11-12. C-Economic Feasibility, Item 4.

The Historical Data Chart is missing the totals for net operating income (loss). Please revise.

Response: Please see the revised Historical Data Chart with the totals for net operating income (loss) included as Attachment 11-12. C-Economic Feasibility, Item 4.

12. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

There appears to be a calculation error in the deductions for operating revenue for the Year 2018. Please revise.

Response: The calculation error has been corrected. In the process of reviewing the data on the historical and projected data charts, the applicant determined that some of the interest needed to be reclassified, so some entries are revised. However, the overall calculations are not affected. Please see revised Projected Data Chart included as Attachment 11-12. C-Economic Feasibility, Item 4.

Please clarify the reason there is an increase in depreciation from $9,442,547 in 2017 to $11,888,976 in 2018.

Response: The increase in depreciation between 2017 and 2018 is the result of the project being completed and in service for an entire fiscal year in 2018, rather than the partial year of 2017.

The Projected Data Chart includes the Years 2017 and 2018. The Project Completion Forecast Chart indicates the initiation of service in March 2018. Please clarify.

Response: The applicant expects the first phase of the project to be completed in the latter part of 2016 or early 2017. The second phase of the project is expected to be completed in March 2018. Phase I is for new construction and Phase II is for the renovation that begins after occupancy of the new building, as indicated on the Project Completion Forecast Chart.

13. Section C, Economic Feasibility, Item 5

Please revise the project's average gross charge, average deduction from operating revenue, and average net charge if there are revisions to the Projected Data Chart.

Response: The typographical errors do not affect any numbers used to calculate average gross charge, average deduction from operating revenue and average net charge.

14. Section C, Economic Feasibility, Item 9

The applicant estimates the TennCare payor mix for the project to be 64% of net operating revenue in Year One. On page 24 of the East Tennessee Children's Hospital Association, Inc. and subsidiaries consolidated financial statement for the period ending June 30, 2013, the TennCare percentage of gross receivables from TennCare is 44%. Please clarify.

What percentage of the total (not net) project revenue is anticipated from TennCare?

Response: The TennCare mix for ETCH is 64% of gross revenue. The audited financial statements show net revenue for TennCare of 44%.

The applicant is projecting approximately $1,397,361, or 1% for charity care. It appears the amount allocated equals .75% charity care. Please clarify.

Response: The amount of allocated charity care equals .75%. The original 1% figure was rounded to the nearest percent.

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15. Section C, Orderly Development, Item 7.b

Please clarify when the Joint Commission Accreditation expires. In addition, please provide a copy of the latest Joint Commission survey summary.

Response: The Joint Commission Accreditation expires on 11/9/2015. Please see the Joint Commission Survey Summary included as Attachment 15, Section C-Orderly Development, Item 7.b.

If you have any questions or require additional information, please give me a call at 850-8722 or by email at Kim.Looney@wallerlaw.com.

Sincerely,

Kim Harvey Looney

KHL:lag

SUPPLEMENTAL- # 1
January 30, 2014
3:00pm

Attachment 15. Section C-Orderly Development, Item 7.b
Joint Commission Survey Summary

The Joint Commission

SUPPLEMENTAL- # 1
January 30, 2014
3:00pm

East Tennessee Children's Hospital Association, Inc.
2018 Clinch Avenue
Knoxville, TN 37916

Organization Identification Number: 7849

Program(s)
Hospital Accreditation
Home Care Accreditation

Survey Date(s)
11/06/2012-11/08/2012

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

DIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	LS.02.01.20	EP1
	NPSG.03.04.01	EP3
	PC.01.03.01	EP1
	PC.02.01.11	EP2

INDIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP9
	EC.02.04.03	EP3
	EC.02.05.01	EP1
	IC.02.02.01	EP4
	LD.04.01.05	EP4
	LD.04.03.09	EP4
	LS.02.01.10	EP9
	LS.02.01.35	EP6
	MS.01.01.01	EP3,EP16
	MS.06.01.03	EP5
	MS.08.01.03	EP3
Program:	Home Care Accreditation Program	
Standards:	HR.01.02.05	EP1

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(c)(5)(i)	A-0358	HAP - MS.01.01.01/EP16	Standard
§482.22(a)(1)	A-0340	HAP - MS.08.01.03/EP3	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP1	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(4)	A-0726	HAP - EC.02.02.01/EP9	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP9, LS.02.01.20/EP1, LS.02.01.35/EP6	Standard

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CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)	A-0951	HAP - IC.02.02.01/EP4	Standard

CoP: §482.53 **Tag:** A-1026 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.53 Condition of Participation: Nuclear Medicine Services

If the hospital provides nuclear medicine services, those services must meet the needs of the patients in accordance with acceptable standards of practice.

CoP Standard	Tag	Corresponds to	Deficiency
§482.53(c)(2)	A-1045	HAP - EC.02.04.03/EP3	Standard

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. The governing body (or the persons legally responsible for the conduct of the hospital and carrying out the functions specified in this part that pertain to the governing body) must include a member, or members, of the hospital's medical staff.

CoP Standard	Tag	Corresponds to	Deficiency
§482.12(e)	A-0083	HAP - LD.04.03.09/EP4	Standard
§482.12(a)(3)	A-0047	HAP - MS.01.01.01/EP3	Standard

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.02.01
Standard Text: The hospital manages risks related to hazardous materials and waste.
Primary Priority Focus Area: Equipment Use
Element(s) of Performance:

9. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous gases and vapors.
Note: Hazardous gases and vapors include, but are not limited to, glutaraldehyde, ethylene oxide, vapors generated while using cauterizing equipment and lasers, and gases such as nitrous oxide.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 9
§482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
The rooftop exhaust vent for the medical vacuum system was not identified with a biohazard label.

Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
The roof top exhaust vent for the Isolation rooms was not identified with a biohazard label.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.04.03
Standard Text: The hospital inspects, tests, and maintains medical equipment.
Primary Priority Focus Area: Equipment Use
Element(s) of Performance:

3. The hospital inspects, tests, and maintains non–life-support equipment identified on the medical equipment inventory. These activities are documented. (See also EC.02.04.01, EPs 2-4 and PC.02.01.11, EP 2)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 3
§482.53(c)(2) - (A-1045) - (2) Inspected, tested and calibrated at least annually by qualified personnel.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
During the individual tracer conducted on the Pediatric ICU, it was noted that a fluid warmer was due for inspection in October 2012 and had not been completed.

Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
During the individual tracer conducted in the Pediatric ICU, it was noted that a pulse oximeter did not have a biomedical equipment sticker that provided information on when the oximeter had been inspected, tested, or calibrated. When questioned, nursing staff could not articulate how they determined if the equipment was safe for use.

Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
During the individual tracer in the Pediatric ICU, it was noted that a portable suction machine did not have a biomedical sticker to determine if the equipment had been inspected, tested, or calibrated.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.01

Standard Text: The hospital manages risks associated with its utility systems.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. The hospital designs and installs utility systems that meet patient care and operational needs. (See also EC.02.06.05, EP 1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site.
The hospitals Medical Gas storage/manifold room is located indoors. The quantity of nonflammable gases in storage plus connected to the manifold is greater than 3000 cubic feet. There is not a means for mechanical ventilation to draw air within one foot of the floor level. Reference NFPA 99 5.1.3.3.3

Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site.
The hospital does not have an Emergency Oxygen Supply connection. Reference NFPA 99 4-3 1.1.1.8

Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site.
In the hospital's locations designated as their 24/7 monitoring stations, an annunciator for the emergency generator status conditions is not provided. Reference NFPA 99 3-4 1.1.1.15

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 4
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
Sterile packs are stored in the ED and are not being monitored for temperature or humidity. Reference ANSI/AAMI ST79:2010 8.9.2 Sterile items should be stored in a manner that reduces the potential for contamination. In general, the temperature in storage areas should be approximately 24°C (75°F). There should be at least 4 air exchanges per hour, and relative humidity should be controlled so that it does not exceed 70% (AIA, 2006)... 8.9.3 The shelf life of a packaged sterile item is event-related and depends on the quality of the packaging material, the storage conditions, the conditions during transport, and the amount of handling. Shelf life is not simply a matter of sterility maintenance but is also a function of device degradation and inventory control. There should be written policies and procedures for how shelf life is determined and how it is indicated on the product....

Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site.
In the Multi specialty clinic a specimen container used for pap smears expired on 10/14/12. It was still available for use during the survey.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.01.05

Standard Text: The hospital effectively manages its programs, services, sites, or departments.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. Staff are held accountable for their responsibilities.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site.
While the air pressure in the operating room #8 was positive, staff interviews revealed the organization performed bronchoscopy procedures in this room. Additionally bronchoscopy procedures are being performed in Endoscopy rooms 1 and 3. These endoscopy rooms, used primarily for GI endoscopies, are by regulation a positive pressure environment. AIA standards require bronchoscopies to be performed in a negative pressure environment with a minimum of 12 air changes per hour. Leadership did not insure that bronchcoscopy procedures were performed in an appropriate environment as required by regulation.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.03.09

Standard Text: Care, treatment, and services provided through contractual agreement are provided safely and effectively.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.
Note 1: In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the 'Medical Staff' (MS) chapter.
Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:
- Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.12(e) - (A-0083) - §482.12(e) Standard: Contracted Services

The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
The hospital has not fully implemented the process of monitoring care, treatment, and services provided through contractual agreement to ensure they are provided safely and effectively. The hospital has implemented this standard with their Team Health contract and plans on reviewing the other clinical contracts.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material. 
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 9
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
At the critical care waiting area room at the fire rated separation of the waiting areas, a penetration of the 30 minute FRR exists due to a low voltage cable not having approved FRR material applied to seal the gap around the cable and the wall.

Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
In the imaging department adjacent to the radiology manager/RSO office, there is a penetration in the one hour FRR smoke barrier due to a 1 1/5 inch conduit sleeve containing low voltage wiring not protected with an approved fire rated material.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Doors in a means of egress are unlocked in the direction of egress. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4) 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
The egress double doors to the emergency department from elevator lobby D on the 1st floor are access controlled and require a key card. A lighted exit sign is mounted directly above the doors designating this is a path of egress. The location is a public corridor.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage. 
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 6
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
In the store room the moveable shelves located in the center of the room have storage that is within 18 inches of the sprinkler deflector.

Observed in Building Tour at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
In the pharmacy a moveable storage shelf supports storage that is within 18 inches of the sprinkler deflector.

Chapter:	Medical Staff
Program:	Hospital Accreditation
Standard:	MS.01.01.01
Standard Text:	Medical staff bylaws address self-governance and accountability to the governing body.
Primary Priority Focus Area:	Credentialed Practitioners

Element(s) of Performance:

3. Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the 'Leadership' (LD) chapter for requirements regarding the governing body's authority and conflict management processes.)
Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.

Scoring Category : A
Score : Insufficient Compliance

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6-11.)
Note 1: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
Note 2: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.12(a)(3) - (A-0047) - [The governing body must:]

(3) Assure that the medical staff has bylaws;
This Standard is NOT MET as evidenced by:
Observed in Medical Management Session at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
Review of the medical staff bylaws revealed that they did not include the requirements needed to comply with MS.01.01.01 EP 16.

EP 16
§482.22(c)(5)(i) - (A-0358) - (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
This Standard is NOT MET as evidenced by:
Observed in Medical Management Session at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
During review of the bylaws, it was determined that they did not include all of the requirements for completing and documenting medical histories and physicals. Although there was some language addressing "who" can perform a history and physical and the "timeliness" for completion, this language was incomplete. In addition, requirements for "updates", "outpatient procedures" and any requirements for "countersignatures" were not addressed.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.06.01.03

Standard Text: The hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

5. The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
- A current picture hospital ID card
- A valid picture ID issued by a state or federal agency (e.g., driver's license or passport)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
Observed in Medical Management Session at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site.
Discussion with staff revealed that the hospital did not have a process in place to do a primary verification of a provider requesting to be credentialed, by viewing a valid ID.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.08.01.03

Standard Text: Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

3. The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s). 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.
This Standard is NOT MET as evidenced by:
Observed in Medical Management Session at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
Review of the hospital's OPPE process revealed that data is periodically collated and given to individual providers. However, the data is not currently being used on every occasion it is collated, to make evaluations and determinations regarding privileging.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.03.04.01

Standard Text: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: 

- Medication name
- Strength
- Quantity
- Diluent and volume (if not apparent from the container)
- Expiration date when not used within 24 hours
- Expiration time when expiration occurs in less than 24 hours

Note: The date and time are not necessary for short procedures, as defined by the hospital.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site.
During an individual tracer of a patient undergoing a procedure, observation of the label on a syringe used to administer Fentanyl revealed that the medication strength (concentration) was not documented on the label.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

Standard Text: The hospital plans the patient's care.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. 

(See also RC.02.01.01, EP 2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
§482.23(b)(4) - (A-0396) - (4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.
This Standard is NOT MET as evidenced by:
Observed in Infection Control Tracer at Children's Home Health Care (11227 West Point Drive, Farragut, TN) site for the Hospital deemed service.
During the infection control tracer conducted on a patient located on 2 West, it was noted that the patient's plan of care did not contain information related to the the patient being on droplet and contact isolation. The plan of care did not contain information or education that was provided to the parents of the patient.

Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site for the Hospital deemed service.
A patient admitted for the inability to maintain body temperature did not have thermo regulation included in the plan of care even though interventions to achieve thermo regulation where being performed. This is a documentation issue and not a patient care issue.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.11

Standard Text: Resuscitation services are available throughout the hospital.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served. 3
Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EPs 2 and 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at East Tennessee Children's Hospital (2018 Clinch Avenue, Knoxville, TN) site.
During the individual patient tracer conducted on the Pediatric ICU, an intubation cart was noted. When questioned, the unit leadership noted this cart was used in emergencies, restocked after use, but was not checked daily as other emergency carts were checked.

Chapter: Human Resources

Program: Home Care Accreditation

Standard: HR.01.02.05

Standard Text: The organization verifies staff qualifications.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

1. When law or regulation requires care providers to be currently licensed, certified, or registered to practice their professions, the organization both verifies these credentials with the primary source and documents this verification when a provider is hired and when his or her credentials are renewed. (See also HR.01.02.07, EP 2) 4
Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. This verification is obtained from the appropriate state licensing or certification board, at the time of hire and at the time of renewal of credentials.
Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.
Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in HR File Review at Children's Home Health Care (11227 West Point Drive, Farragut, TN) site.
Observed in Human Resource file revlew, Nurse Surveyor noted that a primary source verification was not conducted upon license renewal of the Occupational Therapist.

Observed in HR File Review at Children's Home Health Care (11227 West Point Drive, Farragut, TN) site.
Observed in Human Resource file review, Nurse Surveyor noted that a primary source verification was not conducted upon license renewal of an RN.

Observed in HR File Review at Children's Home Health Care (11227 West Point Drive, Farragut, TN) site.
Observed in Human Resource file review, Nurse Surveyor noted that a primary source verification was not conducted upon license renewal of a Pharmacist.

Observed in HR File Review at Children's Home Health Care (11227 West Point Drive, Farragut, TN) site.
Observed in Human Resource file review, Nurse Surveyor noted that a primary source verification was not conducted upon license renewal of the Director of Home Care.

SUPPLEMENTAL- # 1
January 30, 2014
3:00pm

SUPPLEMENTAL- # 1
January 30, 2014
3:00pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: EAST TENNESSEE CHILDREN'S HOSPITAL

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 30th day of January, 2014, witness my hand at office in the County of Davidson State of Tennessee.

NOTARY PUBLIC

My commission expires January 6, 2015

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.
My Commission Expires JAN. 6, 2015

HF-0043

Revised 7/02

JAN 10 '14 AM 11:19

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Knoxville News Sentinel (Name of Newspaper) which is a newspaper of general circulation in Knox (County), Tennessee, on or before January 10 (Month/Day), 20 14 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

East Tennessee Children's Hospital (Name of Applicant) Hospital (Facility Type-Existing)

owned by: East Tennessee Children's Hospital Association, Inc. with an ownership type of non-profit corporation

and to be managed by: itself intends to file an application for a Certificate of Need

for: renovation and expansion of the NICU, Neonatal Abstinence Syndrome Unit, Perioperative Services, and Specialty Clinic located on the Hospital's campus at 2018 Clinch Avenue, Knoxville, TN 37916. The licensed beds are not affected, no services will be initiated, and no major medical equipment will be purchased as a result of this project. The estimated project costs are $75,300,000.

The anticipated date of filing the application is: January 15, 20 14

The contact person for this project is Kim Harvey Looney (Contact Name) Attorney (Title)

who may be reached at: Waller Lansden Dortch & Davis LLP (Company Name) 511 Union Street, Suite 2700 (Address)

Nashville (City) TN (State) 37219 (Zip Code) 615 (Area Code) / 850-8722 (Phone Number)

Kim D. Looney (Signature) 1-10-14 (Date) Kim.Looney@wallerlaw.com (Email-Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: March 31, 2014

APPLICANT: East Tennessee Children's Hospital
1218 Clinch Avenue
Knoxville, Tennessee 37916

CN1401-002

CONTACT PERSON: Kim H. Looney, Esquire
Waller Lansden Dortch & Davis LLP
511 Union Street, Suite 2700
Nashville, Tennessee 37219

COST: $75,302,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, East Tennessee Children's Hospital (ETCH) located in Knoxville (Knox County), Tennessee, seeks Certificate of Need (CON) approval for the renovation and expansion of the neonatal intensive care unit (NICU), neonatal abstinence syndrome unit (NAS, perioperative services, and specialty clinic located on the hospital's campus at 2018 Clinch Avenue, Knoxville, Tennessee 37916. The licensed bed compliment is not affected, no services will be initiated, and no major medical equipment will be purchased as a result on this project.

The proposed project included the construction of 211,499 square feet of new space and the renovation of 67,839 square feet of existing space. Included in the 211,499 square foot of new construction is 40,900 square feet of shelled-in space for future expansion. The square foot cost of the renovation is estimated to be $111.00 and the new construction cost per square foot is estimated to be $224.00 per square foot. The applicant's project compares favorably with the Hospital Construction Cost PSF 2010-2012 compiled by HSDA.

ETCH is owned by East Tennessee Children's Hospital Association, Inc., a not for profit entity.

The total estimated project cost is $75,302,000 and will be funded by a combination of the issuance of bonds and cash reserves. Attachment C-Economic Feasibility-2 contains letters from Zane Goodrich, Vice President for Finance and Chief Financial officer, East Tennessee Children's Hospital; The Chair of Health, Education, and Housing Facility Board of Knox County, and John E. Cheney, Senior Vice President of Ponder and Company, which anticipates providing the financing for the bonds.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:
The applicant's primary service area includes Anderson, Blount, Hamblen, Jefferson, Loudon,

Roane, Sevier, and Knox counties. ETCH also server the remaining counties in the East Tennessee Perinatal Region.

The service area total population projections for 2014 and 2018 are provided in the following charts.

Tennessee Primary Service Area Total Population Projections 2014 and 2018

County	2014 Population	2018 Population	% Increase or (Decrease)
Anderson	75,579	77,851	1.7%
Blount	128,368	135,171	5.3%
Hamblen	64,108	65,570	2.3%
Jefferson	53,729	56,872	5.8%
Knox	453,629	475,569	4.8%
Loudon	50,926	53,192	4.4%
Roane	54,006	54,457	0.8%
Sevier	94,833	100,362	5.8%
Total	**975,178**	**1,019,044**	**4.5%**

Source: *Tennessee Population Projections 2000-2020, June 2013 Revision*, Tennessee Department of Health, Division of Policy, Planning, and Assessment

Tennessee Secondary Service Area Total Population Projections 2014 and 2018

County	2014 Population	2018 Population	% Increase or (Decrease)
Monroe	46,092	48,088	4.3%
Cumberland	57,815	60,292	4.3%
Morgan	21,848	22,004	0.7%
Fentress	18,404	18,987	3.2%
Pickett	5,019	4,943	-1.5%
Scott	21,944	21,969	0.1%
Campbell	41,474	42,566	2.6%
Claiborne	32,604	33,280	2.1%
Union	19,301	19,605	1.6%
Grainger	23,111	23,675	2.4%
Cocke	36,762	38,615	5.0%
Total	**324,374**	**334,024**	**3.0%**

Source: *Tennessee Population Projections 2000-2020, June 2013 Revision*, Tennessee Department of Health, Division of Policy, Planning, and Assessment

2012 Neonatal Intensive Care Beds (Level II-B & II-B) and Pediatric Intensive Care Beds

Hospital	Beds	Days	ADC	Occupancy
Tennova	15	1,396	3.8	25.5%
ETCH	60	19,944	54.6	91.9%
UT Medical	67	15,359	42.1	62.8%

Source: Joint Annual Report of Hospitals (Provisional) 2012, Tennessee Department of Health, Division of Policy, Planning and Assessment

East Tennessee Children's Hospital is the only free-standing children's hospital in the East Tennessee Perinatal Region and was the first certified Comprehensive Regional Pediatric Center (CRPC) in Tennessee, the highest level of certification for pediatric care. ETCH provides a full range of services for pediatric patients including imaging, surgery, NICU, NAS, and pediatric inpatient beds. ETCH operates 152 total beds which includes 79 inpatient pediatric, 60 NICU, and 13 ICU/CCU beds.

The applicant reports ETCH facilities are at their capacity. Over the years, space dedicated as family space in public and patient areas have been reduced or displaced to serve medical purposes. Portions of ETCH were built in the 1970's with renovations occurring in the 1980's and

1990's which are now outdated as well. The facility is operating with outdated design spaces, which does not allow the facility to be utilized with maximum efficiency. Children's hospitals have become much more advanced and changed significantly since ETCH was built. Treatment today not only focuses on treating the child's health issues but incorporating the family in the treatment of the child. The focus areas of the renovation and expansion are the NICU, surgical areas, and the NAS unit.

The renovation and expansion will include the following:

- 10 operating rooms and 4 procedure rooms of which 2 are large ORs (600 square feet) 8 medium ORs (500 square feet), and 4 procedure rooms (400 square feet);
- 48 Pre/Post Op bays for intake, pre- and post-operative care of both inpatients and outpatients in private settings, with options for opening up more rooms between siblings;
- Sterile processing to support surgery and procedure case preparations;
- 44 private NICU rooms (including 4 twin rooms); and
- 16 private NICU rooms for NAS services designed to the level of ICU.

The current pre and post-operative areas are not private, which is now the standard for such services. Dedicated equipment storage does not exist, and surgical corridors are congested and partially blocked.

The applicant currently operates 3 endoscopy/pulmonology rooms and 9 operating rooms. The majority of these rooms are only 330 square feet in size, none of which meet the current standard of 400 square feet.

The NICU will have all private rooms designed for rooming in parents with a sofa bed, storage space for family members, and a controlled environment for the baby and mother. The area will have a family lounge that includes a kitchen, showers, and laundry facility.

The NAS unit will be all private rooms with an individual toilet and will be designed for better monitoring and medication provision.

The applicant has a serious need to upgrade their facilities in order to provide quality services expected from a Comprehensive Regional Pediatric Center.

TENNCARE/MEDICARE ACCESS:
The applicant is TennCare/Medicaid certified. The applicant contracts with BlueCare, United Health Care Community Plan, and AmeriGroup.

The applicant projects year one TennCare/Medicaid revenues of $1,397,361 or 64% of total gross revenues. Charity care is projected to be .75%.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located on page 19 of the application. The total estimated project cost is $75,302,000.

Historical Data Chart: The Historical Data Chart is located in Supplemental 1. The applicant reports net operating income of $27,516,113, $26,407,874, and $12,792,543 in years 2010, 2011, and 2012, respectively.

Projected Data Chart: The Projected Data is located in Supplemental 1. The applicant projects 77,635 and 78,799 patient days in years one and two with net operating revenues of $8,395,624 and $6,364,193 each year, respectively.

The project's average gross charge is $6,050, with an average deduction of $3,680, resulting in an average net charge of $2,370 per inpatient day. The room rates for ETCH are Pediatric beds - $1,923, NICU - $5,387, and PICU - $5,894. ETCH is a freestanding children's hospital and there are no similar facilities in the service area who have comparable charges.

The applicant and their architect and contractor were unable to find any less costly or more effective and efficient alternatives to this proposed project.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
ETCH is a designated CRPC and is required to have transfer agreements with all hospitals in the region.

Only positive effects on the health care system will be realized as a result of this project. ETCH is the only free-standing children's hospital in the East Tennessee Perinatal Region. No other facilities treat children exclusively, therefore, no impact on area providers is anticipated. The physical plant at ETCH is antiquated and the hospital cannot operate effectively and efficiently without renovations and expansion. The quality of services could begin to erode without this project's approval.

The applicant's staffing pattern will not change as a result of this project. No new staff will be hired.

The applicant participates in training programs for the following schools of Nursing: University of Tennessee, South College, Carson Newman College, Lincoln Memorial University, Tennessee Technological University, Tennessee Wesleyan, Walters State Community College, Roane State Community College, and Pellissippi State. The applicant participates in resident rotations for the family practice program at ETSU's Quillen College of Medicine, medical student rotations at Lincoln Memorial University, and the surgical residency program at UT.

ETCH is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Institutions and Accredited by Joint Commission.

A copy of the most recent inspection report and the improved plan o correction is provided in Attachment C-Need-Contribution to the Orderly Development of Health Care, 7(d).

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

   Not applicable.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

      Not applicable.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

      Not applicable.

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

      The applicant reports ETCH facilities are at their capacity. Over the years, space dedicated as family space in public and patient areas have been reduced or displaced to serve medical purposes. Portions of ETCH were built in the 1970's with renovations occurring in the 1980's and 1990's which are now outdated as well. The facility is operating with outdated design spaces, which does not allow the facility to be utilized with maximum efficiency. Children's hospitals have become much more advanced and changed significantly since ETCH was built. Treatment today not only focuses on treating the child's health issues but incorporating the family in the treatment of the child.